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MACKENZIE VALLEY PIPELINE INQUIRY

Government
Publications

IN THE MATTER OF APPLICATIONS BY EACH OF

(a) CANADIAN ARCTIC GAS PIPELINE LIMITED FOR A
RIGHT-OF-WAY THAT MIGHT BE GRANTED ACROSS
CROWN LANDS WITHIN THE YUKON TERRITORY AND
THE NORTHWEST TERRITORIES, and

(b) FOOTHILLS PIPE LINES LTD. FOR A RIGHT-OF-WAY
THAT MIGHT BE GRANTED ACROSS CROWN LANDS
WITHIN THE NORTHWEST TERRITORIES

FOR THE PURPOSE OF A PROPOSED MACKENZIE VALLEY PIPELINE

and

IN THE MATTER OF THE SOCIAL, ENVIRONMENTAL AND
ECONOMIC IMPACT REGIONALLY OF THE CONSTRUCTION,
OPERATION AND SUBSEQUENT ABANDONMENT OF THE ABOVE
PROPOSED PIPELINE

(Before the Honourable Mr. Justice Berger, Commissioner)

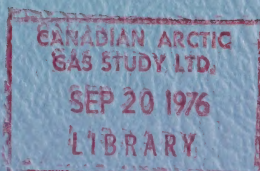
Yellowknife, N.W.T.

September 14, 1976.

PROCEEDINGS AT INQUIRY

Volume 184

347
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Vol. 184



APPEARANCES:

- Mr. Ian G. Scott, Q.C.,
Mr. Stephen T. Goudge,
Mr. Alick Ryder, and
Mr. Ian Roland, for Mackenzie Valley Pipeline Inquiry;
- Mr. Pierre Genest, Q.C.,
Mr. Jack Marshall,
Mr. Darryl Carter, and
Mr. J.T. Steeves, for Canadian Arctic Gas Pipeline Limited;
- Mr. Reginald Gibbs, Q.C.,
Mr. Alan Hollingworth, and
Mr. John W. Lutes, for Foothills Pipe Lines Ltd.;
- Mr. Russell Anthony,
Prof. Alastair Lucas and
Mr. Garth Evans, for Canadian Arctic Resources Committee;
- Mr. Glen W. Bell and
Mr. Gerry Sutton, for Northwest Territories Indian Brotherhood, and Metis Association of the Northwest Territories;
- Mr. John Bayly and
Miss Lesley Lane, for Inuit Tapirisat of Canada, and The Committee for Original Peoples Entitlement;
- Mr. Ron Veale and
Mr. Allen Lueck, for The Council for the Yukon Indians;
- Mr. Carson Templeton, for Environment Protection Board;
- Mr. David H. Searle, Q.C., for Northwest Territories Chamber of Commerce;
- Mr. Murray Sigler and
Mr. David Reesor, for The Association of Municipalities;
- Mr. John Ballem, Q.C., for Producer Companies (Imperial, Shell & Gulf);
- Mrs. Joanne MacQuarrie, for Mental Health Association of the Northwest Territories.

CANADIAN ARCTIC
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1 Yellowknife, N.W.T.

2 September 14, 1976

3 (PROCEEDINGS RESUMED PURSUANT TO ADJOURNMENT)

4 MR. SCOTT: Mr. Commissioner,

5 I think we're ready to begin. I apologize for those
6 counsel who were on the plane that was late and made
7 the commencement of this morning's hearing late.

8 Before Mr. Bayly calls his
9 evidence, I wonder if I could request the counsel to
10 meet me -- counsel or representatives of the partici-
11 pants -- to meet me at the end of the day for about
12 half an hour so we can discuss one or two matters?

13 MR. SIGLER: Sir, I'd just like
14 to announce that we've circulated various papers that
15 the Association, will be presented by the witnesses next
16 week, to all parties this morning.

17 THE COMMISSIONER: All right,
18 thank you.

19 MR. BAYLY: Mr. Commissioner,
20 while we're on these subjects, we have distributed this
21 morning the evidence of Donald Snowden, one of the members
22 of the alternate development possibilities panel who
23 will be giving evidence on Thursday. The evidence of
24 Mr. Currie, the other member of that panel, is presently
25 being typed and should be distributed later in the day.

26 We have one problem with the
27 panel that's before you, Mr. Commissioner, and has
28 nothing to do with the members of it. Dr. Abbott, who
29 was to appear on the panel, has had a back injury and
30 is in hospital. We propose, if counsel have no objections,

Atcheson, Kehoe
In Chief

1 to have Dr. Atcheson read Dr. Abbott's paper into the
2 record. He has discussed it with Dr. Abbott and is
3 prepared to answer questions on it. We are also pre-
4 pared to bring Dr. Abbott to the Inquiry if he is
5 better before it is over, or to answer questions by
6 way of letter, should counsel desire to put any
7 questions to him personally.

8 THE COMMISSIONER: Fine.

9 MR. BAYLY: Before we begin the
10 evidence, if we could go to the qualifications of the
11 two witnesses.

12
13 DR. JOHN D. ATCHESON,

14 JOHN PATRICK KEHOE , affirmed:

15 DIRECT EXAMINATION BY MR. BAYLY:

16 Q If I could begin with
17 you, please, Dr. Atcheson, Dr. Atcheson you prepared at
18 my request the curriculum vitae, which is attached to
19 the back of your formal presentation?

20 WITNESS ATCHESON: I have, sir.

21 Q And if I could ask you
22 to go through that, highlighting those things which
23 pertain to your qualifications as a psychiatrist and as
24 a person who has worked in the north in this field?

25 A Yes sir, I am prepared to do that.

26 Q I understand that you
27 received your academic training at the University of
28 Western Ontario, where you received an M.D. degree in
29 1941.

30 A Yes sir.

Atcheson, Kehoe
In Chief

1 Q And that you worked at
2 the Hamilton General Hospital as a resident surgeon
3 in 1941 and '42.

4 A Yes sir.

5 Q And that you were attached
6 to the Allan Memorial Institute of Psychiatry at
7 McGill University as registrar in 1944 and '45.

8 A I was, sir.

9 Q And that you worked at
10 the Ontario Hospital in Hamilton from 1945 to '46.

11 A Yes sir.

12 Q And at the Toronto
13 Psychiatric Hospital in 1946.

14 A Yes sir.

15 Q And that you received a
16 diploma in psychiatry at the University of Toronto in
17 that year, 1946.

18 A Yes sir.

19 Q And that your clinical
20 -- that you received both a C.R.C.P., which you can
21 perhaps translate for us.

22 A I'm sorry?

23 Q You have a C.R.C.P. in
24 Psychiatry, which you received in 1947.

25 A That's right, that is a
26 Certificate as a Specialist with the Royal College of
27 Physicians & Surgeons.

28 Q And you're a Fellow of
29 the Royal College of Physicians in Psychiatry and
30 you received that appointment in 1972.

Atcheson, Kehoe
In Chief

A I have, sir.

Q And you have a number of
clinical appointments which include the following:
You worked as the Director of the Juvenile & Family
Court Clinic in Toronto from 1947 to 1957.

A Yes sir.

Q And you were consultant
on Training Schools for the Department of Corrections
from 1949 to 1957.

A Yes sir.

Q And you were Director of
Treatment Services at the Department of Corrections
in 1958.

A Yes sir.

Q And Superintendent of
Thistletown Children's Psychiatric Hospital from 1958
to 1969.

A Yes sir.

Q And medical director and
chief-of-staff of Thistletown Regional Centre for
Children & Adolescents from 1969 to 1971.

A Yes sir.

Q And a consultant to the
Eastern Arctic, Department of National Health & Welfare,
from 1965 to the present date.

A Yes sir.

Q And I understand in that
work you make regular visits to the Baffin region three
or four times a year, is that correct?

A At the present time,

Atcheson, Kehoe
In Chief

1 three times a year for anywhere for two to three weeks.
2 sir.

3 Q All right.

4 A At each visit.

5 Q And that you're the
6 senior psychiatrist at the Forensic Out-Patients'
7 Service of the Clarke Institute of Psychiatry.

8 A I am, sir.

9 Q And you have been since
10 1971.

11 A Yes sir.

12 Q And you have held the
13 academic appointments and are a member of the profes-
14 sional associations that are listed in the curriculum
15 vitae.

16 A I am, sir.

17 Q And you're responsible
18 for the publications either on your own or in conjunction
19 with others that have been listed as an appendix to the
20 curriculum vitae.

21 A Yes sir.

22

23

24

25

26

27

28

29

30

1 Q Mr. Kehoe, could we turn
2 to the curriculum vitae at the end of your evidence
3 please? I understand that this was prepared at my
4 request.

5 WITNESS KEHOE: That's right.

6 Q And if I could go over
7 it with you please, you are presently the acting
8 Regional Psychologist of the Yukon Region of the
9 Department of National Health and Welfare?

10 A That's correct.

11 Q And that your
12 qualifications include a Bachelor of Arts Degree in
13 Psychology from the University of Alberta obtained
14 in 1962?

15 A Correct.

16 Q And a Master of Arts
17 Degree in Psychology obtained from the University of
18 Alberta in 1968?

19 A That's correct.

20 Q And you have completed
21 course requirements for a Masters of Arts in
22 Anthoropology from the University of Calgary and
23 anticipate graduation in that course in the present
24 year?

25 A It will probably be next
26 year now. Within the next twelve months' certainly.

27 Q Yes. You've previously
28 been employed, as I understand, as a psychologist with
29 the Provincial Guidance Clinic at Edmonton, Alberta
30 from 1964 to 1968?

Atcheson, Kehoe
In Chief

1 A That's correct.

2 Q And as a personnel
3 technician at the Personnel Department of the City of
4 Edmonton from 1961 to 1962?

5 A That's right.

6 Q Your northern experience,
7 as I understand, includes working as a truck driver-
8 labourer for a Yukon construction company in Cambridge
9 Bay, Northwest Territories for the summer months of
10 1960.

11 A Yes, sir.

12 Q And from 1964 to 1967
13 you were a member of the Consultants Guidance Clinic
14 team making regular visits to Hay River, Fort Smith,
15 Yellowknife, Inuvik and occasional visits to the
16 smaller settlements in this region.

17 A Yes.

18 Q And from 1968 to the
19 present, you have been permanently resident in
20 Whitehorse in the Yukon, except for twelve months
21 leave of absence for your post-graduate studies in
22 Calgary.

23 A That's correct.

24 Q And that your experience
25 includes being a member of the Mental Health Survey
26 team from April through May of 1969, which assessed
27 mental health needs in the Yukon and the Northwest
28 Territories.

29 A That's correct.

30 Q And you've described in

1 your curriculum vitae that survey that was conducted.

2 A Yes.

3 Q I wonder if you would
4 just read that paragraph that describes the survey.

5 A The objective of the
6 survey was to assess the mental health needs of the
7 Yukon and Northwest Territories. The survey was of
8 five weeks duration and covered more than a dozen
9 cities, towns and settlements in the Yukon and Mackenzie
10 District, N. W. T.

11 Public meetings were held
12 at all locations and as well meetings were held with
13 special interest groups, such as civic, territorial
14 and Federal Governments, Indian and Inuit organizations,
15 clergymen, medical practitioners, and private social
16 service organizations.

17 The mental health survey was
18 chaired by Dr. J. D. Atcheson and the two other members
19 besides myself were Dr. Rogers and Dr. C. P. Hellon.
20 All members had had considerable experience in delivery
21 of mental health services in the North, prior to the
22 time of the survey.

23 Q I understand that in your
24 present capacity in the Yukon region, you have held
25 mental health clinics in Inuvik at the request of the
26 Zone Director of the Inuvik zone.

27 A That's correct.

28 Q I suppose that's despite
29 the fact that it would normally be in the region for which
30 Yellowknife is the center?

A Yes, it was a matter of there not being a psychologist in the Territory at the time.

Q Right.

A And my proximity to Inuvik and Whitehorse made it easy for me to make the consultation there.

Q Fine. I understand that your areas of specialization are child guidance, community psychology and cross-cultural psychology?

A That's correct.

Q And that you are a
certified psychologist with the Province of Alberta?

A Right.

Q You're also a member of the professional associations listed in your curriculum vitae?

A That's correct.

Q And you're responsible
either on your own or with others for the reports which
you've listed following your curriculum vitae?

A Yes.

Q Dr. Atcheson, if I could ask you to turn to the submission of Dr. Abbott, whom I understand is a qualified psychiatrist and without reading in his qualifications, read the presentation of evidence that he has prepared for this Inquiry.

WITNESS ATCHESON: As you wish, sir. Mr. Commissioner, when I was requested to prepare a submission for the Commission, I experienced

1 a variety of emotional responses. I felt pleased and
2 honoured to be given this opportunity of presenting
3 some of my thoughts and observations in the North and
4 the impact which development has had on it. At the
5 same time I was deeply troubled with certain misgivings.

6 The number of southern experts
7 who have sprung up like mushrooms has now reached
8 astronomical proportions. The pontifications by the
9 southern experts is a constant source of dismay to me.
10 I am fully aware that by presenting my views before
11 this Commission, I am in grave danger of casting myself
12 in the role of one such expert.

13 However, I will try to resist
14 this temptation as far as humanly possible. After
15 much thought and consideration, together with a study
16 of the literature, I have come to the conclusion that
17 it is a pointless task in attempting to define mental
18 health. I have yet to see anywhere a satis-
19 factory definition as mental health cannot be defined
20 in only clinical terms but must take into account
21 economic, philosophical, religious and political
22 realities.

23 Any definition of mental
24 health, therefore, is bound to be culturally determined.
25 However, although there may be a great difference of
26 opinion in arriving at a definition of mental health,
27 there are certain characteristics by which mental health
28 can be defined and these would be generally acceptable.

29 It is perhaps easier, therefore,
30 to focus on what is not mental health and there is ample

Atcheson, Kehoe
In Chief

1 evidence of what is not if we but look around us and
2 see what is happening in Northern Canada. In the
3 face of alcohol abuse which has reached epidemic
4 proportions, with all the associated ills, family
5 disintegration, violent deaths, injuries, criminal
6 activity, only an ostrich with its head buried very
7 firmly in the sand would deny that development in the
8 North has led to anything but a deterioration in the
9 mental health of the native people.

Atcheson, Kehoe
in Chief

1 I would like first to emphasize
2 that change is inevitable. No society can remain static,
3 when surrounded on all sides by a changing society,
4 without decay. I am not one of those starry-eyed people
5 who would have the native people of the north continue
6 their old trapping and hunting economy in perpetuity.
7 Although the old way of life has served the native people
8 well for centuries, its time is running out. In the
9 same way that European culture has gradually evolved
10 from a hunting and trapping economy, first to agricul-
11 tural economy and now to an industrial economy, so the
12 culture and the way of life of the native people of the
13 north must also change from the basically hunting and
14 trapping economy to an economy in gear with the
15 technology of the 20th century. Those who would have
16 the native economy based on hunting and trapping with
17 no long view of technological developments are in point
18 of fact condemning the native people to the world of
19 museum exhibits. Many people may be rather horrified
20 to contemplate such change and will interpret my state-
21 ments as being a tax on the old native way of life. Such
22 changes do not mean a complete rejection of traditional
23 ways. Changes can be linked to the past, as anyone who
24 has travelled extensively in Europe can see, where there
25 are living examples everywhere of the links of industri-
26 alized European cultures with their agricultural heritage.
27 The Englishman's almost fanatical devotion to his gar-
28 den, however small his may be, is perhaps one of the
29 best examples of the reluctance of the industrialized
30 people to break with all of their tradition. In the

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Atcheson, Kehoe
In Chief

1 same way technological development in the north must
2 develop in such a way that the native people can retain
3 their links with the land and with their old way of
4 life. Although hunting, trapping and fishing may no longer
5 in the future provide the basic economy, these skills
6 are important skills to retain to preserve a sense of
7 identity.

8 Perhaps the Yukon Territory is
9 a very good example of what can happen with rapid
10 unplanned development. We are perhaps all aware of the
11 famous Klondike Gold Rush, and I would recommend an
12 interesting reading, the book "Black Sands and Gold"
13 which is the diary of one of the sourdoughs. Although
14 interesting from the point of view of the life of the
15 sourdough, perhaps one of the most startling features of
16 the book is the lack of mention of the Indian people
17 through whose country the hordes of prospectors traveled.
18 It was as if the native people in the Yukon did
19 not exist. However, although these hordes of sour-
20 doughs had a temporary effect on the native culture,
21 the majority of the sourdoughs left the Yukon Territory.
22 For the native people of the Yukon Territory it was
23 not the prospector who changed their culture as much as
24 the later missionaries, not only from the churches but
25 also in the areas of health, education, etc. But the
26 greatest impact was yet to come. Of even greater
27 significance to the native people of the Yukon was the
28 building of the Alaska Highway and the network of roads
29 that has fanned out from this highway since its
30 development. The Alaska Highway was rushed to completion

Acheson, Kehoe
In Chief

1 in a very short time under great political pressure
2 as Canada and the United States were involved in World
3 War II and the construction of the highway was consider-
4 ed essential for national security of both countries.
5 As an engineering feat, the highway must rank as one of
6 the miracles of the present century. But what has been
7 the outcome of this highway for the Indian people of
8 the Yukon Territory? Towns have sprung up along the
9 highway and most have grown steadily in size. But if we
10 look more carefully at these towns, we see that they are
11 not communities but dual communities. The major centres
12 are basically seven white communities within a nearby
13 native community. When I lived in Whitehorse, the
14 native village was considered a world apart from the rest
15 of Whitehorse. Such development is not limited to the
16 Yukon Territory, and even more tragic examples can be
17 seen in the Northwest Territories. Perhaps the most
18 tragic of all is the situation in Inuvik. Inuvik was
19 a brand new town and a planned community. It was planned
20 in such a way that all facilities were supplied to the
21 government. That, of course, meant white end of town.
22 The native part of town compared most unfavorably. I
23 could go on with examples of the comparison of living
24 standards between the native people and the white
25 southern influx, but it basically makes no difference
26 to me which of the major communities you are looking
27 at, whether it is Whitehorse, Yellowknife, or Inuvik, or
28 many others. The picture is always the same. I do not
29 wish to decry the efforts of certain government depart-
30 ments to improve housing standards for the native

Atcheson, Kehoe
InChief

1 Canadian people, but the point I am trying to make is
2 that in most communities in the north, that have
3 developed, there is an odious comparison between the
4 native and the white areas of town. There are your
5 poor and your wealthy. The poor are always native
6 people. All countries have relatively poor and
7 relatively wealthy people, and it is almost impossible
8 to contemplate a truly classless society. But in
9 northern development in Canada the two groups is split,
10 not only on economic grounds but also on ethnic grounds
11 as well. To compare Riverdale or Porter Creek, which
12 are the white suburbs of Whitehorse, to the Indian
13 Village, is like comparing a new Rolls Royce with a
14 dilapidated worn-out Volkswagen. I have heard the
15 argument that the native people prefer to live
16 separately from the white people. When a comparison is
17 made between the amenities of the southern white
18 suburbia and the native community, I am reminded of
19 similar arguments put forward by the Government of
20 South Africa in support of its apartheid program.
21 The end result of this dual community development has
22 in fact been a form of apartheid. Communication
23 between the native community and the white community is
24 pitifully absent. A large number of white southern
25 Canadians who have moved to the two major centres of
26 the north, namely Whitehorse and Yellowknife, have never
27 spoken to a native person, although they may have
28 lived in the north for a couple of years. Such a condi-
29 tion must reinforce the stereo-typed ideas of the
30 others, and has certainly led to much friction between the

Atcheson, Kehoe
In Chief

1 two groups, usually characterized at the school
2 level where the children betray their attitudes of
3 their parents. How can the white Canadian in the north
4 really understand the problems of the native community
5 when there is no communication? Conversely, how can
6 the native people in the north realize the aspirations
7 and some of the problems of the white person moving
8 north when there is also no communication? A major
9 feature of the development of northern communities has
10 been the lack of control by the indigenous people. The
11 towns have developed in such a way to give the impression
12 that native people have been brushed aside in develop-
13 ment. I will return to this topic of lack of control
14 later on in my presentation.

15 Rather than dwell on the purely
16 physical aspects of the native lot, I would like to
17 focus on what is perhaps much more important, namely, the
18 psychological effects of the above development. In the
19 development of the north, a ruling class has emerged.
20 This ruling class is composed of government officials,
21 civil servants, business owners and managers. They are
22 the people with the jobs. They are the people with the
23 relatively good housing. They are the people with the
24 power. The other classes are the poor, who happen
25 to be the native people. As previously mentioned,
26 they are the group with relatively poor housing. They
27 are the group with no jobs, or a job that is low on the
28 totem pole. They are the people with no power at all.
29 Native people therefore have been placed in the position
30 of inferiority and dependence on the newcomers from the

Atcheson, Kehoe
In Chief

1 south. Perhaps the most serious side effect of massive
2 development today has been a development of a psycholo-
3 gical set of inferiority on the part of the native
4 people. Many of the young people are ashamed of their
5 backgrounds. This was most vividly brought home to me
6 when I was in Whitehorse and held regular group meetings
7 with some of the Indian children at the school. The
8 expression "going down to the Indian Village" was brought
9 up. When I pointed out to the group that this was not
10 an accurate expression because the Indian Village happ-
11 ened to be at a higher elevation than the school, one
12 boy said, "but we are down, we are always down compared
13 to the white man." All decision-making processes have
14 been assumed by private industry or government depart-
15 ments. The family is no longer a viable entity because it
16 has no structure and the native male has perhaps lost
17 more than any other group of people in this country.
18 His role as hunter and provider of his family has gone.
19 He has no job. He is no longer the bread-winner for
20 his family. He has no longer any control over his future,
21 and has lost respect of his wife and his children.
22 Perhaps more importantly, he has lost his own self-respect.
23 The government will take care of his children if they are
24 sick, and government will educate his children. Nowhere
25 is he considered responsible for his family. We have
26 therefore very successfully completely emasculated
27 him. But then we go on to complain that he is not a
28 responsible citizen and not looking after his family
29 properly.
30

Atcheson, Kehoe
In Chief

1 When confronted with the
2 probability of massive development in the Canadian
3 North, accompanied by inevitable major social
4 upheavals I have heard many well-meaning group
5 advocates--group advocate the planning of bigger and
6 better government services.

7 In the face of it, this
8 appears to be a reasonable and a human approach.
9 However, before we get carried away with our missionary
0 zeal towards the native people, let us for a moment
1 look at the present situation. Social disintegration
2 is already with us. In all the major centers of the
3 North there is evidence on all sides. Example,
4 children taken into care, widespread alcohol related
5 problems and the general psychiatric casualties of
6 social breakdowns.

7 To deal with these problems
8 in the North we have already several Federal and
9 Territorial Government agencies providing service to
0 the native people. In fact, the development of the
1 North has been highlighted by a steadily increasing
2 government bureaucracy. It has been my impression over
3 the years that many of the employees of these government
4 departments have given trojan service to the North and
5 I have seen ample evidence of the high regard in which
6 individual doctors, nurses, social workers, and teachers,
7 et cetera, have been held by the local people.

My remarks, therefore, should not be constructed as attacks on all individuals providing these services. However, I must take issue

Atcheson, Kehoe
In Chief

1 with the system that has evolved in the Northwest
2 Territories. This system, whether it be in the area
3 of health, education or social development or many
4 other government departments are basically southern
5 white Canadian models transposed to the Canadian
6 Arctic.

7 As one moves further from the
8 field level of operation and closer to the final
9 decision-making authority, whether this rests in
10 Yellowknife or Ottawa makes absolutely no difference,
11 any input from the native people gradually peters out.
12 From the field level of decision-making authority level,
13 the system more and more approximates the bureaucracy
14 of Southern Canada.

15 Here and there, in the
16 Government System, the odd token native appears giving
17 native input. But the system is such that there are
18 safeguards built in that the native input in no way
19 influences decisions. We are left, therefore, with a
20 situation of all decisions affecting the native people,
21 being decided by a group of white professionals from
22 the South who control all policy, make decisions and
23 budgets.

24 This is complicated by the
25 existence of many people whose personal power is out
26 of all proportion to their inherent abilities and
27 qualifications. When I first went to live in Whitehorse
28 I was quickly thrust in the role of being the oracle
29 of all psychiatric wisdom in the North, simply because
30 I was the first psychiatrist to live north of the 60th

1 parallel. It is very difficult not to succumb to the
2 temptations of such power.

3 Many times in the North, I
4 have thought of the expression, "In the valley of the
5 blind, the one-eyed man is king". Such a system with
6 all its inherent problems and dangers only intensifies
7 the demarcation of natives and non-natives in the
8 Northwest Territories. The non-native is the giver.
9 The native the receiver. The non-native is the
10 controller. The native person is the control. The
11 non-native is the adult and the native person is a
12 child.

13 However, I have detected
14 marked unhappiness with this system on both sides.
15 The native people are no longer content to be left
16 out the decision-making process and are becoming more
17 increasingly militant and vocal as has been amply
18 demonstrated at this Commission of Inquiry. Many of
19 the non-native people working in the North have become
20 increasingly frustrated with the lack of results in
21 their programs. For them, unfortunately the option
22 of being vocal too often do not exist and the north
23 has lost many good workers because they can no longer
24 stand the system.

25 Given the above, therefore,
26 I have many reservations and recommendations on
27 recommending that in the area of psychiatric services,
28 Government builds up a bigger and bigger service. We
29 have to recognize the limitations of southern white
30 North American psychiatry in helping native people.

In Chief

Mr. Abbott then submits a series of recommendations sir. Although at the beginning of this address, I stated that I would try to resist the temptation to make recommendations on the future of the people of the North, there are certain highlights that should really be very obvious to anybody who has travelled and seen the North. Development of the Canadian North is inevitable and probably in the long run will be beneficial to the native people, but only if certain provisions are made and changes are made

1 in the present system. These points perhaps can be
2 numbered best as follows:

3 1. Development must proceed
4 in a planned and organized fashion and not one of panic
5 development. By planned and organized development,
6 I do not mean that it is planned in some remote
7 office in Southern Canada and is imposed on the people
8 of the North. Planning presupposes full consultation
9 of the native people with assumption of decision-
10 making authority by the native people.

11 2. It is difficult to see
12 how the topic of native land claims can be dealt with
13 in isolation from planning development. The two topics
14 must obviously be dealt with simultaneously.

15 3. Tied in with land claim
16 settlement and development of the North, the goal must
17 be to develop positions of authority filled by native
18 people. This applies to both economic development and
19 to government agencies. It must be therefore recognized
20 that in predominately native areas, the ultimate goal
21 will be full authority to be wielded by the local
22 native people. Although it must be recognized that
23 for considerable time to come, certain expertise will
24 continue to come from white southern Canadians, moving
25 to the North. The ultimate goal must be full authority
26 in areas of social welfare, health, education, community
27 development, et cetera, to be wielded by the native
28 Canadian person. This would include both policy making
29 and budgetry decisions.

30 4. As a corollary to the above,

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1 the native people must also recognize that once they
2 have assumed full authority of policy and budgets, they
3 will in turn also assume full responsibility.

4 5. Increasing efforts must
5 be directed towards training Northern people to assume
6 the roles of the developer, an effort to circumvent the
7 possibility of a massive influx of southern Canadians.
8 Methods should perhaps be explored of alternate means
9 of employment and payment. Southern economic wealth
10 is not in all probability conclusive to mental health--
11 conducive to mental health. An excellent example
12 of this is shown in Ross River, the Yukon, where many
13 of the men of the community were sent on a prospectors
14 course and were paid for attending this course.

15 Although the intention was
16 admirable, the sudden acquisition of money led only
17 to an increase in trade in the local bar and to several
18 deaths the first winter; people being drunk and
19 freezing in the snow. If therefore, a large part of the
20 native population are going to change to a wage economy,
21 it is essential that some training be given in handling
22 budgets to help ensure that the families of the employed
23 person are the ones that really benefit.

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6. Although I realize that the human condition tends to be very short-sighted, I would make a very strong plea to look at long-term development of the north. I direct this plea not only to governments, who are notoriously unable to think beyond the next election, but also towards the native people. What will the economy of the north be 50 years from now? How can secondary industry be encouraged in the north? Let us not forget that Dawson City in the Yukon Territory was once the largest city in North America west of Chicago but its economy was based on a boom, and of course the bust followed later. How and can secondary industry be encouraged in the north? Perhaps greater efforts should be placed in investigating an economy based on non-depleting resources, such as lumbering and the tourist industry. Already the north has developed a tourist industry, but unfortunately again it is highlighted by white southern Canadians and Americans coming in and developing this industry. The benefits to the native people have been generally minimal. Can a local horticulture and agriculture development be achieved? Are such developments reasonably viable, and what can be done to train native people to develop such a diversified economy?

To summarize, in summary the north is already in a stage of development. Development has unfortunately been achieved by southern Canadians coming north to develop it. The roles of the native people have been largely those of recipients of service and observers of development. Control over development

1 must not be placed -- must be placed at least to a
2 large extent in the hands of the native people. The
3 native people in turn must recognize that such control
4 brings with it full responsibility and accountability.
5 Psychological development of the north has been high-
6 lighted by a parent-child relationship with the white
7 southern influx are parents and the native people are
8 the children. As long as this psychological set remains
9 there is no hope for the development of strong, secure
10 and organized communities in the Northwest Territories
11 and psycho-social problems will continue unabated or even
12 increase. A whole army of psychiatrists, psychologists,
13 social workers, and other allied professions marching
14 around the north will not save it. They will make no
15 dent whatsoever on the extent of the problem that we
16 are seeing at the present time, and that are likely to
17 increase. As long as the answer to future development
18 and increasing problems is to build bigger and better
19 government services, to help the native people, the
20 psychological set of dependency will be maintained and
21 reinforced. We must get to the root cause of these
22 problems, which is basically that of people without con-
23 trol of their own destiny. The past answer of buying
24 off people with handouts is destructive, not only to
25 those receiving but also to those giving.

26 I respectfully submit this
27 for Dr. Abbott, Mr. Commissioner.

28 THE COMMISSIONER: Thank you,
29 doctor.

30 MR. BAYLY: O Thank you, Dr.
Atcheson.

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1 I wonder, Mr. Kehoe, if we could then turn to your
2 presentation and have you read that into the record,
3 please?

4 WITNESS KEHOE: My submission
5 is entitled:

6 "Some Mental Health Implications of Large
7 Scale Northern Development."

8 Mr. Commissioner, may I
9 begin by briefly identifying my reason for coming
10 before this Inquiry? I am first of all a northerner
11 having lived and worked in Whitehorse, Yukon Territory,
12 as a permanent resident for over eight years. I identify
13 with the Canadian north and its people, and I therefore
14 have a very real stake in its orderly development.

15 Q Could you move the micro-
16 phone a little bit closer, Mr. Kehoe?

17 A Sorry.

18 Q And speak perhaps a little
19 bit more slowly.

20 A My experience is not
21 confined to the Yukon. I have visited and worked at
22 least briefly in most of the major settlements and towns
23 in the Western Arctic at some time in the past 15 years
24 and I have some familiarity with the overall social
25 condition of the area and with its social problems.

26 In presenting this
27 testimony to the Commission, I am acting as a private
28 citizen appearing on behalf of the Committee for Original
29 People's Entitlement. My opinions derive in large mea-
30 sure from my work experience in the north, but they are

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1 not necessarily shared by my employer. I will state
2 at the outset that I have a serious concern for the
3 possible effects of pipeline development on the people
4 of the north, and particularly on the native people.
5 In my testimony I intend to point to some of the mental
6 health implications of this sort of rapid, social and
7 technological change for the native people, who are
8 the only residents we can feel sure will still be here
9 when the developers are long gone.

10 I am going to follow the
11 unhappy but well-established precedent of using the
12 racial term "white" to refer to the people and culture
13 of Southern Canada as a whole. By "native" I will mean
14 the Canadian Inuit and the Athabaskans or Dene and those
15 of mixed descent who are living in the contemporary
16 indigenous lifestyle. It might be noted parenthetically
17 that the words "Inuit" and "Dene" can be loosely trans-
18 lated "the people", a fact which underlines the strong
19 traditional sense of identity and which will be shown
20 to be of considerable relevance for mental health.

21 The Anchorage Borough Planning
22 Department stated in its report of Pipeline Impact in
23 May 1975, that,

24 "one of the greatest but almost indefinable impacts
25 is on emotional and mental health."

26 Similar vague but ominous warnings are given in various
27 Canadian news and technical reports and have been made
28 in testimony before this Commission.

29 The vagueness, I suggest, re-
30 flects in part the failure of the relevant sciences

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1 and arts to come to grips with the problems of
2 definition and evaluation of mental health. It might
3 be noted that many experts have despaired of every
4 being able to do so.

5 Mental Illness, the obverse
6 side of the coin may at first glance seem more readily
7 definable. We somehow seem comfortable in applying
8 disparaging labels to those we fear, dislike, or do not
9 understand. It is generally acknowledged, however,
10 that the absence of recognizable mental illness is not
11 a reliable index of mental health. In fact, survey
12 studies of the prevalence of symptoms of mental illness in
13 both white and native populations have shown that such
14 symptoms occur in a significant proportion of the people
15 in the populations studied but only a small percentage of
16 these are ever identified as clinically mentally ill,
17 meaning that only a small percentage would ever be
18 referred for psychological or psychiatric treatment.
19 It has been said by a Canadian psychiatrist with
20 considerable experience in the north that behavioural
21 deviance is becoming a cultural norm amongst the natives.
22 This statement, it might be noted, was made in 1968.
23 He was referring to those types of behaviour disorders
24 which, while not conforming exactly to our psychiatric
25 diagnostic categories, do impair development, physical
26 health and social adjustment and which mitigate against
27 the realization of full human potential and happiness.
28 He relates this type of symptom to cultural erosion and
29 I will be returning to this topic later.

30 It is not surprising that

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1 we have failed to arrive at a satisfactory definition
2 of mental health when one realizes that a definition of
3 health per se has eluded the World Health Organization.
4 That body concludes that physical health is something
5 more than freedom from disease. It is described as,
6 "an active, dynamic, integrated state."

7 By analogy, mental health is defined as something more
8 than just freedom from mental disease. While most mental
9 health experts subscribe to this definition, it has
10 recently been argued that the disease or medical model
11 is not wholly appropriate to the task of understanding
12 the diverse behaviour we call disease. Mental illness is
13 really only a metaphor, a figurative way of speaking
14 about behaviour that is unpleasant or unacceptable
15 to oneself or to society.

16 An alternative to the
17 medical model substitutes the disease concept of mental
18 illness with a social learning concept that sees man
19 as a social creature who acquires through learning and
20 experience various modes of solving inter-personal problems.
21 Some of these solutions or strategies may be successful
22 under some conditions and not successful under others.
23 Disordered behaviour may follow from attempts to solve
24 certain problems of living which are generated not by
25 things going on in one's head, but by the social systems
26 which both produce the stress and teach one the strategies
27 for coping with it. We respond to our personal diffi-
28 culties in ways we have learned and which are culturally
29 determined. 50 years ago hysterical paralysis was a
30 fairly common symptom in psychiatry. Today after decades

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1 of subtle changes in our own culture, it is virtually
2 unknown. Depression, anxiety and duodenal ulcers on
3 the other hand, have become as familiar as the common
4 cold. Apparently our social experiences determine the
5 choice of adaptive techniques available to us, and can
6 even favor the development of certain symptoms such as
7 acute anxiety, withdrawal, bizarre behaviour, or alco-
8 hol abuse. When we can no longer meet the demands
9 or expectations of our particular social environment
10 in an acceptable way, we are left with those failing
11 strategies which we popularly regard as signs and
12 symptoms of mental illness.

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This model applies to the bulk of the traditional catalogue of mental diseases and includes the types of dysfunctional and socially destructive behavior which are described as being so prevalent in the North. These include alcohol abuse, depression, anxiety, aggressiveness, and various personality disorders.

It does not apply quite as well to the mental disorders caused by brain impairment such as acute and chronic brain syndromes and mental deficiency, nor does it satisfactorily explain many psychotic disorders such as schizophrenia or manic-depressive psychosis. Still, the way even these disorders manifest themselves is in part learned and culturally conditioned.

It should be noted that these categories, the psychoses, are not thought to be more prevalent in the North except so far as some of them may result from other types of disorder behavior. For example, alcohol abuse may lead to chronic brain dysfunction. Child neglect may lead to functional mental deficiency in the child and violence may lead to traumatic brain damage.

There are, in fact, insufficient data at present to get a reliable picture of the total range and prevalence of psychopathology in the Canadian North. There are several problems to be faced in trying to draw together these data, including the fact of a widely dispersed population, incomplete health and social statistics, still developing systems of

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1 health and social services, and a system of classi-
2 fication and diagnosis that is not necessarily valid
3 or useful in diagnosing local and cultural variants
4 of disordered behavior. At best the data are
5 impressionistic, and it is my guess that they will
6 remain so for some time to come. We must acknowledge
7 that we are starting from an uncertain data base but
8 I suspect you will find a fair consensus among mental
9 health, medical and social service personnel as to the
10 seriousness of the problem.

11 Returning to the other side
12 of the coin, mental health, the social learning model
13 provides an understanding of how one achieves the
14 desired active, dynamic, integrated state which was
15 given as a definition for health, and that is through
16 the establishment of one's social identity. This refers
17 to the process whereby we acquire our reason for being.
18 We do this through roles we assume as husband, wife,
19 provider, hunter, community leader, seamstress, trapper,
20 healer, and so on. These roles, of course, only make
21 sense within the individual's own cultural context.

22 I suspect that the role of
23 psychologist or lawyer is no more highly valued in a
24 small Mackenzie River settlement than that a trapper
25 would be in Metropolitan Toronto. Mental health is
26 further encouraged by being positively evaluated by
27 significant others in one's ability to perform his or
28 her acquired roles. This means that if those who
29 matter to you--

30 THE COMMISSIONER: What was that

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1 again? Mental health is further encouraged by being--

2 WITNESS KEHOE: Positively
3 evaluated by significant others.

4 THE COMMISSIONER: By signifi-
5 cant others.

6 WITNESS KEHOE: I'm sorry sir.
7 I can't hear you.

8 MR. BAYLY: Perhaps you could
9 explain, Mr. Kehoe, what the adjective "significant"
10 means in the--

11 THE COMMISSIONER: Oh,
12 significant others. I follow you, sorry. Forgive
13 me. This is very, very interesting and fairly densely
14 packed. Maybe we could just take a five minute break
15 and then you could continue. Would you mind if we
16 did that?

17 (PROCEEDINGS ADJOURNED FOR A FEW MINUTES)

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1 (PROCEEDINGS RESUMED PURSUANT TO ADJOURNMENT)

2 THE COMMISSIONER: All right,
3 we'll come to order again, ladies and gentlemen .

4 MR. BAYLY: Q Mr. Kehoe, could
5 I ask you to continue your paper at page 6? I think
6 you were in the first paragraph. In fact you might go
7 back to the beginning of the sentence that starts at
8 the bottom of page 5, in the last line.

9 WITNESS KEHOE: I suspect that
10 the role of psychologist or lawyer is no more highly
11 valued in a small Mackenzie River settlement than that
12 of trapper in metropolitan Toronto.

13 MR. SCOTT: Mr. Bayly, did he
14 have to read that over again?

15 MR. BAYLY: Just in case Mr.
16 Scott was not listening the last time.

17 A Mental health is further encour-
18 aged by being positive/ evaluated by significant others,
19 and I apologize for what is currently a jargon expres-
20 sion there, "significant others", but it refers, as
21 I explained in the next sentence, to those people who
22 are most important in your lives, in effect.

23 This means that if those who
24 matter to you judge you a success in a role that
25 matters to them, you are that much more immune to be-
26 havioural disorders.

27 A third condition for mental
28 health is that the individual be actively and success-
29 fully engaged in actually performing the required roles.
30 These concepts can be made clear by considering the

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1 simple example of what happens when the conditions are
2 not met. It has been demonstrated that the very common
3 disorder known as reactive depression occurs more
4 frequently in married women, their role being that of
5 wife and mother, whose efforts to perform that role
6 are not acknowledged by someone who matters to them,
7 such as their husband or their children, or who are not
8 permitted to perform that role for some reason beyond
9 their control, such as after the death of a spouse,
10 or when the last child leaves home.

11 If the opportunity to inact
12 the roles we acquire / ^{in life} is removed or denied, and if
13 positive confirming evaluations are withheld, we become
14 good candidates for so-called mental illness. As a
15 person's ability to perform meaningful and valued
16 roles is reduced, their chances of eventually resorting
17 to mal-adaptive behaviours and ineffective coping
18 strategies is increased.

19 Again I will stress that the
20 criteria for success or failure are social, and that
21 the only significant evaluation as far as the individual
22 is concerned is that made by those who matter most to
23 him.

24 I will attempt to demonstrate
25 how these destructive factors are presently operating
26 amongst the northern natives and I will argue that their
27 effects could be accelerated by pipeline development.

28 The term "culture" has a fairly
29 precise meaning to anthropology but it is at best only
30 poorly understood by laymen, and is the cause of much

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1 confusion. I shall be using the term to mean a shared,
2 coherent, ideational code and all of its products. A
3 culture in other words, is a way of doing things and
4 of understanding things which is held in common by a
5 people. It is far more pervasive and comprehensive
6 than the popular idea of culture as native handicrafts,
7 subsistence style or even religion or language. It is
8 the underlying design or code by which a people live
9 and which allows for predictability in their social
10 relations.

11 The rules of one's cultural
12 code are mainly unconscious and are seldom brought to
13 awareness until they are contrasted with those of another
14 culture. Invariably the other culture comes out looking
15 second best in such a comparison. We are the people;
16 this is our way; it is best for us.

17 It is within our culture that
18 we achieve our social identity, our reason for being.
19 My existence makes sense and I am mentally healthy to
20 the extent that I am able to achieve and play out roles
21 consistent with what is expected of me and what is
22 desirable within my culture. At the same time, my cul-
23 ture must make sense to me and it must be coherent. If
24 a dual and incompatible set of expectations are placed
25 on me, I have to resolve that incompatibility or suffer
26 the consequences. One possible consequence is to resort
27 to a system of failing strategies, again what we might
28 call mental illness.

29 It goes without saying that
30 the white culture has had a tremendous impact on the

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1 native cultures in the north. Some of the influences
2 are powerful and blatant. For example, in his testimony
3 before this Commission, Dr. Charles Hobart has charac-
4 terized the educational policy of the N.W.T. as actually
5 promoting cultural replacement. In my personal opinion,
6 the same holds true in the Yukon where the Territorial
7 Government invokes a principle of equal education for
8 all to justify a curriculum that in fact puts native
9 children at an extreme disadvantage. Likewise, churches
10 have been aggressive in their attempts to undermine and
11 discredit the ways of life and thinking of the native
12 peoples. This is the end and essence of religious
13 proselytizing. Indian Affairs Branch follows or has
14 followed an implicit policy of assimilation. Social,
15 health, correctional and judicial services in the north
16 are modelled after their southern counterparts and
17 operate from the same white value system, one which is
18 not necessarily shared by the people they serve. These
19 institutions are unfamiliar and often strange and
20 frightening to the native people because they are so
21 intrusive and often at odds with the native's way of
22 doing things. It is ironical that in order to benefit
23 from our institutions and to communicate with us, they
24 must become like us and on our terms.

25 Devaluation and discrediting of
26 the native cultures continues at the level of informal
27 interactions. Open prejudice is not hard to find. White
28 people tend to evaluate the behaviour of the native
29 people with a white man's yardstick. In my own experience,
30 for example, native school children are over-represented

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1 proportionately in referrals to me and typical referral
2 statements by white middle-class professionals are
3 couched in evaluative, prejudicial terms. A typical
4 native child would be described -- and I emphasize this
5 this is a typical child, not one who is necessarily
6 emotionally or otherwise disturbed -- would be des-
7 cribed as immature, a follower, unambitious, depressed,
8 set in his ways, insensitive, and as feeling inferior
9 and avoiding responsibility. Judged from the
10 Protestant ethic of worldliness, individualism, ration-
11 alism, and competitiveness, these adjectives are approp-
12 riate. But in all likelihood these children are
13 displaying behaviour in this situation (usually the
14 school situation) that is appropriate, correct and re-
15 warded by their own culture. They are discovering and
16 learning by observation; they are showing proper reserve
17 in the presence of an adult stranger, especially a white
18 man; they are being unassertive and co-operative rather
19 than competitive; and they are inhibiting emotional
20 expression. Perhaps they really are feeling inferior,
21 but one could easily see why they would and why they
22 might eventually display emotional distress and behaviour
23 disorders.

24 This insensitivity to the
25 cultural origins of behaviour and its functional
26 utility within that culture is fairly common in my
27 experience. The result is that the native's experience
28 with white man almost everywhere tells him that his values
29 and his way of life are inferior, that they are inap-
30 propriate to modern times, and that he is childish or

irresponsible or incompetent or primitive. To make matters worse, he has become economically dependent on white man and his institutions. So far, modernization has meant dependence and poverty of the Canadian native. We thus have a so-called Indian problem or an Eskimo problem.

The result for the individual native person is a sense of loss of identity and purpose. Male and female role functions are usurped and even the fundamental task of socializing their own children is denied them. Important social and economic relations are disrupted. There is a loss of autonomy and a subsequent lack of control over social, economic, political and administrative systems. Bob Sharp spoke before this Commission of the far-reaching social effects of the very simple matter of the construction of permanent homes for the natives of Ross River. It is an insidious process by which both men and women are slowly deprived of the traditional roles which normally bestow power, ceremony, wisdom and adventure.

I have talked to numerous native people, many as clients, who described to me their personal frustration, despair and sense of worthlessness in the face of the growing white community, and as the numerical dilution continues this feeling is likely to grow. Both adolescents and adults have expressed shame about their traditional ways; some adolescents have even expressed contempt for both their parents and their ways. I have observed children and adolescents applying tremendous pressure on their

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1 parents to behave like white man, and old people lamenting
2 the loss of respect for adults that once characterized
3 their relationship between native adult and youngster.
4 Hobart spoke of the

5 "massive devaluation of things native, at least
6 on the part of the young people" in this,
7 he is referring to the delta area,
8 " and of their loss of self-respect."

9 A 20-year-old Inuit from Inuvik who came to me as a
10 client in Whitehorse last year told me how he had even
11 denied to a white woman that he was an Inuit. This
12 man was intelligent, articulate and fully aware of how
13 he was caught up in an acculturation process in which
14 to this point he'd had no choice.

15 Recently a white teacher des-
16 cribed to me an experience she had in which a class of
17 adult Indian women who were discussing the role of their
18 traditions suddenly began crying. They all shared a
19 sense of loss of Indian identity and were left with the
20 feeling that they could not go back and they did not
21 belong here. Others have said in effect, "I am not an
22 Indian any more, but if I am not, who am I?"

23 I apologize to the Commissioner
24 if I am belaboring the obvious, and I am aware that
25 others have presented substantially the same evidence
26 with regard to the impact of white culture on the native
27 people of the north. The redundancy should serve,
28 however, to underline the common experiences and
29 observations of social scientists and social service
30 personnel in the north.

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From the model presented earlier and the abundant evidence of cultural breakdown, we should predict a high incidence of disordered behaviour, or if you prefer, mental illness among the native people. I have described the population with limited access to highly valued, achieved roles, whether these be white or traditional; where people are given roles that are incompatible with their traditional values; where there is a discontinuity between the old ways and the new; where traditional roles, such as hunter, trapper, shaman and so on, are devalued or discredited entirely; and where the old standards by which self-esteem was regulated are increasingly identified as irrelevant.

High rates of alcohol abuse, crime and family breakdown especially are cited as indices of psychological strain among the northern natives. They represent as well a breakdown in traditional collective arrangements for maintaining social order. These behavioural disorders are individual responses to the social stresses that accompany acculturation and they are highly visible. The drunk, the juvenile offender and the welfare recipient are easily recognized as being in some kind of social and personal distress, but many disorders are less obvious. For example, an obvious similarity exists between the set of conditions just described and those which were described earlier as being responsible for the disorder known as reactive depression.

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This disorder is recognized by a set of symptoms including passivity, lack of interest, decrease in energy, difficulty in concentration, lack of motivation and ambition, and a feeling of helplessness. These symptoms can vary in degree and from person to person and culture to culture. It has been suggested by many of my colleagues in psychology and psychiatry that this disorder is virtually endemic among the northern native people but at a sub-clinical level or perhaps simply unrecognized as depression. By sub-clinical I mean that again it wouldn't come to the attention of personnel working in the mental health field.

These people do not come forward for treatment because, a) they perhaps do not recognize the nature of their distress, b) our mental health institutions and services are still inappropriate to their particular cultural conceptions of how to deal with personal problems or, c) the community itself tolerates or supports the sufferer with a kind of fatalism. Whatever the case, they go untreated.

Other responses to the disruptive stresses of acculturation are possible and depend, as was said earlier, on the coping strategies that are tolerated, expect or even encouraged by the community. I refer you, Mr. Commissioner, to the very pertinent study by Dr. Joesph Lubart on the psychological problems of adaptation of the Mackenzie Delta Eskimos. He describes in detail how the culture shapes the response of the individual to psychosocial stress,

1 and he provides some illustrations of the dynamics
2 of individual cases of disordered behavior.

3 I have already mentioned the
4 difficulty of determining the prevalence of mental
5 disorder among the relatively small, scattered and
6 culturally heterogenous population of northern native
7 people and I will not try here to give any estimates.
8 It would at best be only a crude impression and it could
9 be misinterpreted. It might also distract from the
10 more relevant task of identifying those positive factors
11 which make for mental health amongst the Inuit and Dene.
12 Suffice it to say that there is a serious concern among
13 health professionals for the mental health of the native
14 northerner and that this concern centers on the problems
15 arising from acculturation and rapid social change.

16 Experts in the field of mental
17 illness and acculturation claim unequivocally that
18 acculturation, when rapid and extensive, has a damaging
19 effect on mental health. Perhaps the boundaries of the
20 concept acculturation are about as vague as those of
21 mental health and mental illness but I use it here to
22 refer to the process whereby cultural elements such
23 as customs, knowledge, values, technology and material
24 objects of one culture are adopted in whole or in part
25 by another. The problems that occur when the recipient
26 culture cannot incorporate the changes either because,
27 a) the new element is too exotic or unusual or otherwise
28 incompatable with the existing culture, or, b) because
29 the change is too rapid for other aspects of the culture
30 to absorb the shock.

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1 I might add here, an analogy
2 I saw recently of acculturation as being similar to
3 somebody who is trying to rebuild their house while
4 they're still living in it. It could be done but it
5 would have to be done systematically and very carefully
6 in order not to disrupt the vital functions of a
7 household.

8 Abruptly introducing large
9 scale wage employment into a community which formerly
10 subsisted largely on hunting and fishing could have
11 widespread ramifications and affect the community in
12 unexpected ways. For example, removing the male head
13 of the family so that he could work at a remote site
14 could disturb a whole complex of important social
15 and economic relationships. What happens to a community
16 where kinship factors are strong, when men at the peak
17 of their social influence are suddenly removed for
18 extended periods of time? When several of the principal
19 actors are removed, social and political alliances must
20 change and the new organization may create more serious
21 problems, especially on the return of the men.

22 It may be argued that men
23 already leave their communities in large numbers and
24 for extended periods of time for the purpose of hunting
25 and trapping and they might just as well be working on
26 a pipeline. In my experience, however, hunting and
27 trapping expeditions of any duration are rare and only
28 seasonal. Often the whole family accompanies the man
29 and each member has a role to play in the activity.
30 Family members are seldom separated for any length of

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1 time. Witness the high turnover rate amongst native
2 people who have been employed in similar situations
3 in the past. Going to the bush is qualitatively
4 different in other ways from going to work. It is most
5 importantly an independent decision of a small related
6 group, such as a family or two; it is comprehensible
7 and functional in the traditional economic and social
8 life of the community; and it bestows dignity and
9 prestige.

10 Partly acculturated young
11 natives who otherwise disparage the native way of life,
12 especially in the presence of whites, will still speak
13 admiringly of the successful hunter or trapper or the
14 man who handles himself well in the bush. Even they
15 will talk about going back to the bush, figuratively
16 and otherwise, in order to get away from the stresses
17 and discouragements of town life. Not long ago I
18 teasingly challenged a group of five young Indian
19 women, all of whom were employed full-time in middle
20 class occupations, by suggesting that they were too
21 well acculturated to be able to survive in the bush.

22 The outrage in their response
23 took me my surprise. I had obviously touched a tender
24 nerve and they made it plain to me that their primary
25 identification was with the bush life and with being
26 Indian. They were actively and aggressively teaching
27 their own children pride in the Indian language and
28 way of life in order to protect them from the in-
29 dignities and hurt they'd experienced in their own lives.

30 Some of them, incidentally,

1 had suffered serious personal problems because of their
2 own acculturation experiences. Two of this group,
3 none of whom had ever been psychiatric patients, had
4 at one time in their lives been seriously depressed
5 and suicidal.

6 Wage employment in some
7 culturally meaningless task is a vastly different
8 experience from traditional economic pursuits. It
9 contributes directly to the acculturation process, that
10 is, it draws the native person deeper into our way of
11 life, without necessarily contributing to the emergence
12 of a fuller native way of life. Intensive development
13 can only be expected to accelerate the acculturation
14 process with dubious short-term benefits for the
15 individual but probable long-term damage to his or
16 her cultural identity or sense of well-being. We can
17 expect that family and marital relations will be
18 adversely affected and that the socialization of the
19 child will be changed.

20 The opportunity to directly
21 profit from pipeline development cannot possibly be
22 evenly distributed throughout the community. What
23 happens to those individuals and families who are
24 without manpower or marketable skills to sell to the
25 pipeline? They will surely suffer from the inevitable
26 inflation as more money enters the community. In some
27 there will no doubt be an induced sense of inadequacy
28 and uselessness as they recognize the disparity between
29 their neighbour's material wealth and their relative
30 poverty.

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It has been said that development always increases this disparity rather than reducing it. Can we not expect a growth of the population of marginally acculturated town dwellers? Many people will be induced to move to the larger centers where there is apparently more opportunity and I can see this happening despite the best efforts of a pipeline developer to discourage it.

We can also expect an influx of speculators, opportunists, adventure-seekers, escapists and other transients who are attracted to such developments. The native people will somehow have to learn how to deal with them and the inevitable exploitation.

There is, I believe, no way to contain the culturally disruptive white influence during a period of rapid development. Even during normal times, as Hobart has noted, commodities and influences which first find their way into Inuvik very rapidly and he italicized very, very rapidly diffuse to the outlying areas. Who will help the native people cope with these influences and how will they incorporate the changes without the disruption in their personal lives which we are anticipating?

These sorts of questions must be asked in the interest of prevention of mental illness because they relate to how successfully an individual can find and fulfill a meaningful role in his society.

If what is already a difficult

1 task for the Inuit and Dene is made more difficult
2 by exposing them to rapid technological and social
3 change, we can expect their frustration to intensify.
4 The World Federation for Mental Health in its report
5 for UNESCO on cultural patterns and technical change
6 described what might be expected if these frustrations
7 are allowed to persist. This report is over twenty
8 years old and was written for the general acculturation
9 situation, yet its conclusions might well have been
10 written for today, for the northern native and for
11 this Commission. It suggests the following possible
12 consequences of failure to adjust to the new pressures:

- 13 1) A return to old forms of behavior which are now
14 less satisfactory.
 - 15 2) The individual's behavior may become less mature,
16 his feelings and emotions may be more poorly
17 controlled, or new forms of dependency may develop.
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1 5. The accumulated tensions may find expression in
2 aggressive acts, both physical violence and verbal
3 attacks, and the objects of such acts may not be at all
connected with the frustrating situation or agent;

4. The individual may withdraw psychologically or physically. Withdrawal may be into apathy, into substitute activities such as alcoholism, drug abuse, gambling, or into nativistic cults which seek to recover a golden age; or

10 the individual may reduce his tensions by partially
11 avoiding the tension-provoking situation. In this
12 case the end resolved tensions still exist and may be
13 expressed through apparently unrelated behaviour such
14 as chronic fatigue, preoccupation of one's health,
15 compulsive ritual or endless and fruitless searches for
the causes of ones problems.

17 the same report included
18 a consideration of how to make technological change
19 and social change more acceptable and less psychologically
20 damaging. It suggests that "the most important single
21 fact to be kept in mind is that new techniques must be
22 introduced with proper regard for existing culture and
23 with as little violence as possible to the folkways of
24 the group concerned" and that "a first consideration
25 from the standpoint of mental health in the
26 introduction of any technological change should be the
27 safe-guarding of the population against further mental
28 health, against the expression in individual lives of the
29 disorganization and disruption accompanying the intro-
duction of new techniques and ways of living."

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1 In short, it is necessary
2 to take into account the whole culture when any
3 particular change is introduced and unless that is
4 done various types of socially and personally
5 destructive changes may be set in motion.

6 It has been suggested
7 that the responsibility of public health and preventive
8 psychiatry is to see that acculturation is paced so
9 as to humanize it.

10 Emphasis is placed on
11 understanding exactly what is in progress before an
12 innovation is made. A distinction must be made here
13 between self-generated social change, which is a
14 continuous process in all cultures, and the rapid,
15 externally imposed acculturation pressures that accom-
16 pany large scale development.

17 I suggest, Mr. Commissioner,
18 that it should be incumbent on any developer in the
19 north to demonstrate in the interests of the mental
20 health of the people of the north that any proposed
21 developments are congruent with the habits and needs of
22 the people. It is naive to think that giving people
23 jobs will solve their social problems and it could even
24 aggravate them as I have suggested.

25 Locally initiated
26 development can make for improved mental health because
27 it allows for meaningful involvement -- a necessary
28 condition for achieving the social identity of which I
29 spoke earlier. The people must see the development as
30 theirs in order for it to make sense to them and they

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1 must be the major beneficiaries. Local control of
2 development allows for an expression of communal values
3 and encourages novel, culturally determined solutions
4 to the social problems accompanying development.
5 Without that control they must live with it and make
6 the best of what is happening to them.

7 Finally, Mr. Commissioner,
8 I would ask, who is prepared to deal with the
9 anticipated personal and social problems if the
10 pipeline goes through? Alaska mental health and social
11 services are being sorely tried by the effects of
12 pipeline construction as you are aware. Mental health
13 practitioners in the north will admit that we are not
14 yet very good at helping native people with mental
15 health problems and now we find ourselves with
16 the prospect of a dramatic increase in the social
17 stresses to which they will be exposed -- more white
18 people, sudden wealth and perhaps equally sudden poverty,
19 changes over which they have no control, and so on.

20 Will it be necessary
21 to provide an army of psychiatric, social service,
22 correctional, welfare and community development personnel
23 to pick up the pieces -- and if so, is this a cost that
24 has been anticipated by the pipeline proponents? I
25 suggest it would be more economical -- socially as well
26 as financially -- to prevent the problems from ever
27 occurring in the first place.

28 That concludes my
29 submission.
30

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THE COMMISSIONER: Thank

you, Mr. Kehoe.

MR. BAYLY: Mr. Commissioner,
to complete this panel, there is a presentation by
Dr. Atcheson of his own paper and I am in your hands,
sir, as to whether we proceed with that now or wait
until after the lunch break.

THE COMMISSIONER: Well, let's
have lunch and come back at 2:00 to hear from
Dr. Atcheson.

We'll adjourn until
2:00.

(QUALIFICATIONS & EVIDENCE OF A.P. ABBOTT MARKED
EXHIBIT 759)

(QUALIFICATIONS & EVIDENCE OF J.P. KEHOE MARKED
EXHIBIT 760)

(PROCEEDINGS ADJOURNED TO 2 P.M.)

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(PROCEEDINGS RESUMED PURSUANT TO ADJOURNMENT)

MR. BAYLY: I wonder, Dr.

Atcheson, if I could ask you to turn to the submission which you have prepared for the Inquiry and read that into the record please.

WITNESS ATCHESON: Yes, sir.

Mr. Commissioner, in accepting a request to address the Commission, I must first clearly identify the nature of my experience in the Arctic communities. I present my point of view with some degree of apology as no one appreciates more than myself the multitude of self-assigned experts that exist concerning the Canadian Arctic.

The arrogance of the experts or specialists who, without a capacity to communicate with the native people and lacking in appreciation of their history, visit this uniquely important constituency of Canada on a few occasions and immediately expound the best methods of dealing with the welfare of its citizens and preserving their culture, has contributed to vast misunderstanding of the problems.

Frequently the repressed and sometimes over-hostility of the native Canadian people to this pseudo-expertise is blandly unrecognized by the experts.

I am able to address this issue only from a relatively narrow experience. In 1965 I was requested along with colleagues in the disciplines of psychology and social work, to assess

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1 the mental health that were presenting in the eastern
2 Arctic. After this initial experience, I have annually
3 and since 1971 three times a year, served a
4 psychiatric consultation in a small part of the eastern
5 Arctic, the Baffin zone, namely the settlements of
6 Pangnirtung, Cape Dorset and the town of Frobisher
7 Bay. I have had occasion to visit in some other
8 communities in the zone but basically my awareness
9 is related to these three areas.

10 The responsibility for
11 arranging these consultations is shared by Dr. Samuel
12 Malcolmson, Dr. Eric Hood and myself, all of whom are
13 members of the staff at the University of Toronto,
14 Department of Psychiatry, and we have been able to
15 achieve a continuity of service that we feel has
16 greatly enriched our awareness of the mental health
17 problems of the eastern Arctic. This continuity has
18 made it possible for us to have many contacts with
19 administrative personnel, educational personnel,
20 health personnel and more importantly significant
21 native Canadian people.

22 In my early consulting role,
23 this contact with my Eskimo fellow citizens was
24 through interpreters. We are extremely sensitive to
25 the difficulties of fully appreciating a culture when
26 one has no skill in the language, which is the major
27 constituent of any culture and we have been very
28 sensitive to our inadequacies and have been very cautious
29 in making broad generalizations concerning the mental
30 health of the people.

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1 In recent years our contacts
2 have been increasingly with Eskimo people, especially
3 young people, who speak excellent English and who are
4 patient enough to communicate and discuss their
5 problems with us.

6 Over this ten year period
7 I've had the opportunity of seeing the effect of perhaps
8 the most rapid cultural change that has ever been
9 experienced by a group of Canadian people. Although
10 a slow erosion of the Eskimo culture has been taking
11 place over the last century, the state of change and
12 the sudden thrust of the southern community dating
13 from the end of World War II, but more precisely and
14 intensely over the last ten years, could not be re-
15 duplicated any place in the world.

16 Although it is true that there
17 are many ethnic groups in our vast country who have
18 faced the horrendous problem of cultural clash and
19 assimilation into the southern culture, they, as a
20 rule, have done this on their own election and under
21 conditions that in no way resemble the problems that
22 native Canadian people have faced, as the values of
23 the southern culture have been imposed upon them.

24 The motivation of the cultural
25 invasion has rarely been based on a sympathetic
26 understanding and respect of the native culture. We
27 have imposed in the native Canadian people a political
28 and a public health system, a religion and a concept
29 of laws, not entirely based on the reality of their
30 circumstance. This has been enforced by a political

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1 philosophy which identifies with the sanctity of private
2 ownership, whereas the native culture conceives the
3 world as their land and to be shared but never to be
4 owned.

5 To deny that this rapid speed
6 of change has had no negative effects on the native
7 Canadian people would be to deny the reality of
8 increased violent death, dependency on alcohol,
9 aggressive, hostile and anti-social behavior, anxiety,
10 depression and behavior disorders of childhood.

11 It is difficult to offer a
12 universal definition of what is meant by mental health
13 and I agree fully with my colleague, Mr. Kehoe, in
14 this difficulty. We do, however, appreciate that it
15 somehow is related to that capacity in the human being
16 to adjust comfortably to the stresses of a particular
17 environment. Mental health may be defined as the
18 capacity of the individual to adapt to his environment
19 so that he may satisfy his basic needs and be
20 productive and creative; thus fulfilling his individual
21 potential in such a way that he feels relatively
22 independent, happy and secure within the boundaries
23 of his physical capacity and the limits of the social
24 structure in which he exists and with which he is in
25 dynamic harmony.

26 The historical description
27 of the Eskimo culture would indicate that the people
28 had arrived at a unique homeostatic condition
29 with a most hostile environment.
30

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1 It is readily observed that
2 when a culture begins to lose its identity and a diffu-
3 sion of roles of parents and children takes places,
4 that the appearance of an increasing instance of
5 pathological depression is the inevitable consequence.
6 There can be no doubt that as a result of the cultural
7 erosion in our Arctic, that an increased incidence of
8 serious depressive reactions has occurred. If we then
9 provide a system that we have become accustomed to using
10 in the south to deal with our stress, namely the intake
11 of alcohol, we have all the components that are necessary
12 for a marked distortion of mental health.

13 We have observed an increased
14 incidence of violent behaviour which is often the result
15 of this depression released by alcohol and resulting in
16 anger. The battered child syndrome, for example, is
17 now observed in a culture whose former child rearing
18 practices were based on the concept that the child was
19 always wanted, either by the biological parents or by
20 the extended family, and where early childhood learning
21 took place through patient example by the parents
22 demonstrating the responsibility of their roles.

23 The pattern of suicide, for
24 example, has changed from the noble, voluntary withdrawal
25 by the sick or the aged, with the welfare of others
26 as the motivating force, to suicide of despair and
27 a sense of uselessness in roles so diffuse that life
28 has no rewards that can be perceived by the depressed
29 mind.

30 One of the most sensitive

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1 indices of abnormal social tensions in any culture
2 is the appearance of increasing delinquency in children
3 in adolescence, and indeed, in anti-social deviant
4 behaviour. This increase in anti-social deviant
5 behaviour as described in the well-documented monograph
6 by Finkler, Szabo and Parizeau,

7 "Deviancy and Social Control Manifestations,
8 Tension and Conflict in Frobisher Bay,"
9 should, in my opinion, be carefully reviewed by all
10 members of this Commission.

11 The observations that I have
12 made in relationship to the Eastern Arctic are primarily
13 related to communities where in fact there is no strong
14 economic base for their existence. When one carefully
15 examines the economic position of the Town of Frobisher
16 Bay, it would be necessary to assume that there is no
17 basic industry that contributes to an income to this
18 community. Indeed, there are some excellent artists
19 who carve and there are those who are employed in terms
20 of transportation and maintenance of utilities, but in
21 fact there is no product and everyone who is engaged in
22 Frobisher Bay is basically there looking after someone
23 else.

24 I can only comment that under
25 these conditions one observes a lack of well-defined
26 roles for the majority of the native Canadian people. This
27 modification of role from the earlier days of the camp
28 and hunting culture was clearly described by Dr. Otto
29 Schaeffer in a most important address that he gave
30 to the Third International Symposium on Circumpolar Health

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1 in 1974. It is through a century of exploitation of
2 the native Canadian people that we have succeeded in dis-
3 rupting their culture and values, and most regrettably ,
4 lowering their self-pride. This present generation has
5 been placed in a position more difficult than those of
6 their father's, and most probably more difficult than
7 their son's. The deviant social behaviour resulting
8 from this clash of cultures and the ambivalent oscillations
9 between new and old values themselves produce a type of
10 "survival of the fittest" crucible, in which some cas-
11 ualties are precipitated. These will occupy psychiatric
12 consultations for a generation or more.

13 One might make an inference
14 from these statements that if in fact there were only
15 a wage-earning economy, and a gross national product of
16 the Eastern Arctic, then in fact this diffusion of roles
17 from the native person -- for the native person would be
18 corrected. This statement implies that the native
19 Canadian person would be offered the opportunity of
20 adequate and appropriate training to fulfill a new role
21 in a new wage-earning economy, and it also presumes that
22 it would be his wish to accept this role.

23 From the evidence that I can
24 obtain of the impact, for example, of the pipeline and
25 the Alaskan native people, there is little evidence to
26 sustain this point of view. If it is known and agreed
27 that sufficient energy exists in the north to merit its
28 transportation to the markets of the south, it is
29 difficult to believe that this can be prevented. It is,
30 however, reasonable to assume the planning for such

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1 enterprise could take place with the thoughtfulness and
2 with the controlled timing that would permit for the
3 appropriate planning not only ecologically and
4 technically, but for the rights and welfare and advance-
5 ments of all Canadians.

6 I am of the opinion that the
7 point of no return has been passed in terms of stating
8 that if the southern culture would withdraw, the native
9 Canadian people would re-establish their former cultural
10 state. In the present global village, this is obviously
11 impossible and perhaps not desirable. This very fact
12 increases the responsibility of our government to
13 approach this problem with every possible plan, to safe-
14 guard the welfare of Canadian people in the process of
15 transition.

1 We must use every possible
2 effort to discover techniques to carry out this process.
3 If we agree that the philosophy involved is to effect
4 change in a way that it will better the majority of
5 Canadian people and destroy none, then we must establish
6 a policy which will permit the effective development
7 of such a philosophy.

8 I understand that this
9 Commission has addressed itself to many issues of
10 policy, such as the safety of this pipeline for the
11 ecology of the country, and to the tremendous cost
12 that is involved, to the question as to whether we
13 really have sufficient technical knowledge to cope
14 with these issues. Every now and then I hear a
15 question raised as to the rights of those who will
16 be most affected by this change, namely those Canadian
17 people who use this land in their cultural way at the
18 present time.

19 There will continue to be
20 for some time native Canadian citizens who wish to
21 continue a hunting and trapping economy. It is indeed
22 their land and if we really mean that we're all equal
23 citizens in Canada, then it means that we deal fairly
24 with the issue of ownership. In my opinion, without
25 an appropriate and completely honest appraisal of
26 native people's land claims, then anything that follows
27 in attempting to identify techniques that will allow
28 this transition from the hunting settlement economy to
29 that of the wage earning economy of the South will be
30 doomed to immense failure.

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1 Since the breakdown in living
2 that I have described, and which I identify with the
3 phenomena of cultural erosion, presents patterns of
4 behaviors such as aggression, delinquency, family
5 breakdown, et cetera, that are increasing in our
6 southern culture, it is obvious that we have not
7 discovered suitable techniques to prevent totally this
8 deviant social behavior.

9 It would be my recommendations
10 that in the same manner as huge sums of money have
11 been directed towards exploration in discovering the
12 energy sources in the north, appropriate budgetting
13 be considered to research methods of effecting change
14 without destruction. This cannot be dealt with by
15 funds alone, although such are necessary. It cannot
16 be dealt with by sociological experts from the south,
17 although they will have a contribution of great
18 significance. It will mean resourcing the native
19 leaders and professional experts in behavioral
20 sciences in a way that they may meet in colleagueship,
21 seeking a new system to deal with the existing
22 problems. I am convinced that ^{if} the same energies and
23 monies were directed towards researching the problems
24 of human behavior, such as aggression and breakdown
25 in living as we have directed towards solving the
26 technical problems of the pipeline, that ^{if} we might all
27 learn how we might walk on the land together.

28 In summary, sir, I submit
29 my opinion that the rapid imposition of the southern
30 culture on the citizens of the northern communities

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1 with the arrogant and unjustified assumption that it
2 is a preferred system and good for the people, has,
3 in fact, created social deviancy.

4 There is much evidence of an
5 increasing incidence of breakdown in family living
6 and traditional value systems and, as a consequence,
7 within the broad definition of mental health, an
8 inability to adjust comfortably to the new social
9 system has been the result.

10 To deal with these problems
11 we have tried to utilize traditional methods of
12 delivering health services, social services, educational
13 resources, and legal process with very little input
14 from the native people, and with little thought as
15 to whether traditional patterns of service from the
16 south have any practical applications in the north.

17 We have very little evidence
18 to substantiate that the process has been successful,
19 if the measure of success is the comfortable adaptation
20 of people to the new social structure.

21 There has been only limited
22 consultation with the native Canadian people as to how
23 the transition might be achieved, assuming that it is
24 desirable. It would be my first recommendation that
25 a permanent commission, somewhat resembling perhaps the
26 Law Reform Commission of Canada be established to review
27 these issues and to make suitable recommendations to
28 Government.

29 Its task would be to examine
30 and design new types of systems that would be appropriate

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1 in effecting the evolution of the southern and northern
2 cultures to achieve a new and meaningful Canadian
3 culture. If such could be effected by peaceful means,
4 it would make history.

5 Such a commission should be
6 composed of native Canadian people with some social
7 scientists and economists who are well experienced in
8 the northern communities and indeed there are such
9 Canadians who would be members of this Committee by
10 invitation.

11 Such a commission should
12 be constantly receiving input from many sources and
13 would be the most competent instrument to recommend
14 change and education, social development and economic
15 policies that would allow for the integration of the
16 north without its destruction.

17 If the citizens of the nation
18 are to exist comfortably together, their actions must
19 be the result of a philosophy of sharing and basic
20 trust. Certain policies are necessary to make such
21 a philosophy a productive model.

22 Every citizen must expect to
23 share in the resources of the land and be permitted,
24 as far as security of all will allow, to exercise his
25 individual and collective rights.

26 My second recommendation would
27 therefore be that I suggest that for the effective
28 sharing of resources, an equitable formula must be
29 struck to deal with the land rights of the native
30 Canadian people.

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1 If a successful resolution of
2 these claims is not achieved, we will continue to
3 reinforce the feelings of discrimination that future
4 generations will have to resolve and which history
5 demonstrates has been the genesis of unrest and
6 violence in much of the so-called civilized world.

7 I make a strong plea with the
8 object of achieving a state of mental health for all
9 Canadian citizens, that we address ourselves to the
10 problem of creating a new culture, a new society,
11 in which the rights of all citizens are held as sacred.

12 I respectfully submit this,
13 Mr. Commissioner.

14 MR. BAYLY: Now, just before
15 cross-examination, I asked both of you members of the
16 panel to look at the recommendations that had been
17 made by the members of the panel called by the Northwest
18 Territories Mental Health Association. You've had
19 an opportunity to do so and if you have any comments
20 on those recommendations, I wonder if you could give
21 those.

22 A Yes, sir.
23 I have had the opportunity of reviewing the recommen-
24 dations that you referred to. Philosophically, I agree
25 with all of them. I think in terms of some of the
26 techniques and perhaps policies that are suggested to
27 bring that philosophy into effect, I would hesitate.

28 I think we have not yet
29 sufficient input and I believe that recommendations
30 coming from the native Canadian people should, in fact,

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1 be taken into consideration before change, such as
2 changing where the delivery service comes from, et
3 cetera, are put into effect. But basically I have
4 no great disagreement with the statements that were
5 made by this association. I think there would be
6 some technical difficulties in carrying some of them
7 out, certainly in terms of transgressing perhaps some
8 civil rights in terms of the nature of conditions of
9 employment and so forth for pipeline personnel.

10 I would have some concern in
11 that technical sense but I think the philosophy behind
12 it is to say let us not bring in disorder or let us
13 not create disorder by what we bring in. I think that
14 that needs much more examination before one has a
15 clear way of doing it.

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1 Q Mr. Kehoe, did you have
2 any comments to add to that in those recommendations?

3 WITNESS KEHOE: I would agree
4 with Dr. Atcheson. I might just add perhaps one thing
5 from our experience in the Yukon with regard to dis-
6 couraging transients from coming to the Territory in
7 search of work. The Yukon Territory has in fact been
8 affected by the Alaska development, despite Alaska's
9 attempts to discourage transients and people seeking
10 work. It has been affected in the sense that people
11 will go perhaps just as far as the border where they
12 try to -- were trying to suggest they could go back
13 home from whence they came, and the people would often
14 go back as far as Whitehorse and they would there take
15 up residence in the bush and become welfare recipients,
16 creating of course social problems for our own community.
17 This is only an opinion, but I think it would be very
18 difficult to enforce some of those kinds of restrictions
19 that the Mental Health Association is looking for with
20 regard to who might come into the Territory during a
21 period of development.

22 Otherwise, I am in principle --
23 in agreement with the principles that the Mental Health
24 Association has stated.

25 MR. BAYLY: This panel is now
26 available for cross-examination and as I stated, sir,
27 they are prepared to answer questions on Dr. Abbott's
28 presentation if they are addressed to them.

29 THE COMMISSIONER: Just before
30 you begin, Mr. Kehoe, both Dr. Abbott and you and Dr.

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1 Atcheson I think too, but you articulated this in your
2 paper. You said that,

3 It is the condition of a whole people, the
4 discernible to them, erosion of their culture
5 what they perceive to be an inferior place that
6 members of their race occupy in the larger world,
7 that that gives rise to depression on the
8 one hand and anti-social behaviour on the other
9 hand that it really cannot be treated by psychia-
10 trists, or which counselling and government
11 assistance of one kind or another is not really
12 going to be helpful.

13 Both Dr. Abbott and you discussed that at length. Now,
14 if I've got the theory more or less right, he concluded
15 his paper by saying,

16 So it will do no good to have all these white
17 people from the south trained in psychiatry and
18 social work and so forth and so on marching around
19 the north because they wouldn't do any good.

20 It is a state of the -- it is the condition of the people
21 and state of their culture that has to be examined.
22 Now is that a view that is held widely in the literature
23 and among the leaders in this field? What I am getting
24 at, is you're not, I take it, telling me that something
25 that is -- you're not giving me a view of this thing
26 that is held by Dr. Abbott and you only! Would you just
27 comment on that, if I'm making any sense?

28 WITNESS ATCHESON: Indeed you
29 do, sir, and I think that I would like to qualify that
30 implication that my particular branch of medicine has

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1 a limited part to play. We certainly identify classical
2 mental illness, if I may use that term, psychotic illness
3 of a type that we can recognize, in which we have an
4 armentary of treatment that can be helpful.

5 One of the principles of the
6 treatment of mental illness is to treat that person
7 where they live, and not to move them from that community
8 to a resource of discomfort and unfamiliarity. So
9 obviously the -- even though we can make application
10 and can treat certain types of mental illness, we need
11 the assistance of native Canadian people to guarantee
12 the continuing welfare, the secondary support systems
13 for such people. I believe that is where we can play
14 a marked role.

15 In view of our knowledge of
16 the causation of breakdown in the development of the
17 human being, the lack of security if the family is
18 destroyed, I think we can play a part in a consulting
19 way. We can use that knowledge to bring others together
20 and make use of it too, and we can be a secondary type
21 of support system in that regard.

22 But by and large, and I would
23 draw upon the example that has been recently identified
24 in Frobisher Bay. I cannot recall the number of times
25 that I as a psychiatrist have gone to Frobisher Bay and
26 been asked, "What do you intend to do about the problem
27 of alcoholism? Surely that is the big presenting
28 problem."

29 We have no distinct answer for
30 this, and my profession could not give a distinct

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In Chief

1 answer to it. Some months ago, in the month of April
2 of this year, under the leadership of very competent
3 native Canadian people, a petition was taken throughout
4 Frobisher Bay, signed by sufficient numbers that the
5 Commissioner found it important^{and} indeed called upon to
6 close the Liquor Store outlet. Sometime before
7 that a plebiscite of our political system had been taken
8 which was unsuccessful. I suggest that this is a demon-
9 stration of the competency of the native people to
10 bring together and resource themselves and to deal with
11 the problem. It's my feeling that this is an important
12 description.

13 In terms of deviancy, again I
14 would draw from the example that is taking place in
15 Frobisher Bay and which we could well emulate in southern
16 communities, and that is in the field of juvenile
17 delinquency where a Juvenile Court Committee was estab-
18 lished again by native Canadian people, it wasn't
19 generated by the specialists from the south; the people
20 there said, "Our children misbehave; the Mounted Police
21 pick them up. We would like to have an opportunity to
22 see them first." A question of diversion from the Court
23 system, and this indeed is having some remarkable
24 results. A great number of delinquent children are
25 being dealt with by their elders, native Canadian people
26 well-respected, who will discuss the issues of the
27 child's misbehaviour with their parents, will set up
28 certain conditions around the child and indeed I think
29 we could take an example from this type of project.

30 This is the type of inter-

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In Chief

1 action I think we can play a part in; I think sometimes
2 we can be catalytic in bringing it about, but it has
3 to happen at the grass roots level of the people them-
4 selves.

5 WITNESS KEHOE: Mr. Commissioner,

6 I think one of the questions you asked me was whether
7 or not the position that Dr. Abbott and I seemed to be
8 taking was peculiar to us. I think I can explain that
9 best by describing the kind of psychology and psychiatry
10 we intend to do as being a community psychology,
11 community psychiatry. I concluded my presentation with
12 the suggestion that there may have to be, I think I
13 used the term "army" of professionals of various sorts
14 and social services to deal with the social problems
15 if they develop. I think this would be the tendency
16 and at this point in time perhaps it's the only way we
17 could proceed. In fact, my own preference, the
18 approach I'm trying to develop in my own practice in the
19 Yukon is not to develop an army of social service
20 personnel in the area of mental health, but to address
21 myself more to social problems in the sense that Dr.
22 Atcheson was talking about as a consultant, as someone
23 who can put a certain kind of perspective on the behaviours
24 that are being observed as community problems and perhaps
25 suggesting remediation from that perspective.

26 So this is still a developing
27 kind of approach. I think there are a lot of questions
28 unanswered. I am just vaguely familiar with the approach
29 that's been used in Alaska with community or regional
30 mental health workers. That's been in effect for quite

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1 some time. It may be one of the kind of solutions we
2 can try. Unfortunately, it's going to take some time
3 before we can really develop the expertise in the
4 communities to deal with mental health problems.

5 Does that answer the
6 question?

7 THE COMMISSIONER: Yes.

8 WITNESS ATCHESON: Mr. Commis-
9 sioner, if I may just add one further point? The ques-
10 tion in my history of going up as a consultant to the
11 Eastern Arctic, it has often been posed to me, "Are you
12 coming up here to see we white people, or are you coming
13 up to see the Eskimos?"

14 This division of thought,
15 two types of human beings that a psychiatrist might be
16 interested in is completely unfounded. We have a practice
17 in the Eastern Arctic where we deal and attempt to
18 correct from psychiatric procedures many problems with
19 non-native Canadian people who are there. We also have
20 dealt with mental illness in terms of Eskimo or native
21 Canadian people. The uniqueness is not typically the
22 native Canadian person. I wish to make the point that
23 the psychiatric needs are not at all all directed
24 towards the native Canadian.

25 MR. SCOTT: Mr. Sigler?

26
27 CROSS-EXAMINATION BY MR. SIGLER:

28 Q Yes, I'd like to pose a
29 general question to the panel. After reading and then
30 hearing all three of the papers that you presented today

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Cross-Exam by Sigler

1 I'm left with the impression that really the substance
2 of your analysis is that the problems here of the people
3 are defined on racial lines, and with the impression
4 that a lot of generalizations have been made about
5 races of people. Don't you think that this type of
6 analysis is a dangerous one when you're dealing with
7 people and perhaps that that's been the government's
8 mistake in trying to deal with the native people as a
9 general group of people without looking at individual
10 problems? What I'm getting at, the impression from the
11 evidence I get is the very general analysis perhaps,
12 maybe it's not a fair one, but I'm left with the
13 impression that you generalized a lot about races of
14 people and I'm saying, to what degree is it a problem
15 of individual people or a community problem at best?
16 To what extent can you fairly and really analyze the
17 problem with these generalities about entire races of
18 people?

19 WITNESS ATCHESON: I'm not too
20 sure that the opinion I direct to your question is directed
21 towards a race of people, but a race of people in
22 a particular circumstance, under conditions under which
23 it's being confronted and I wish to correct that point
24 of view that the psychiatric disability is related to
25 the native person entirely. There is a population of
26 Canadian people who live in the Arctic and
27 function and are governing it and running it, who are
28 prone to the same disorders as people in the south, and
29 my profession can in fact help in some individual cases
30 in an individual way. When we set up a treatment program

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Cross-Exam by Sigler

1 for a psychiatric problem in the Arctic we use the
2 same individual process that we would in the south.
3 But aside from that there are these elements, that is
4 cultural interface, which indeed are created very
5 unique problems.

6 Q What are they? Go ahead.

7 WITNESS KEHOE: If I could just
8 add a few comments. First of all, I think our presen-
9 tation maybe has a bit of a bias which is because we
10 are representing the Committee for Original People's
11 Entitlement, we're speaking for them. Our emphasis is
12 on problems, on difficulties that people experience, and
13 I think we could turn around and do the same kind of
14 thing for the white people of the north, and in fact
15 it's been in done. In fact I've done it, speaking about
16 the living difficulties of people who come from a
17 southern community and try to exist here.

18 THE COMMISSIONER: Will you
19 pull the microphone a little closer?

20 A Sorry. So what I'm saying
21 is that if we appear to be focusing on race, I don't
22 think we intended to. Certainly we were acknowledging
23 that there were cultural differences. These cultural
24 differences are represented in individuals. We feel
25 individuals who present with a certain symptom, something
26 that's bothering them, or represented to us by society
27 because they're creating some kind of problems. I
28 don't think this is a racial issue, but we have to
29 recognize that the people have different values, the
30 indigenous people have different values from us and

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Cross-Exam by Sigler

1 we are simply acknowledging that in trying to develop
2 different kinds of approaches to their personal
3 problems.

4 MR. SIGLER: Q Is it not
5 dangerous, perhaps even a little racist, to generalize
6 about any people, whether it's the native people or
7 the white people? Can you make broad generalizations
8 about people?

9 WITNESS ATCHESON: I think
10 you can make broad generalizations about people, and
11 let us for the moment remove the question of race, who
12 find themselves under particular conditions of stress.
13 I don't think there is any implication that the native
14 Canadian people and the type of stress that they're
15 experiencing would react any differently than we would.
16 The question was when I first went to the Eastern Arctic
17 as a consultant, it was primarily with children and in
18 the school system, and I was told by teachers that
19 one teacher I can recall saying,
20 "90% of the children in my class have a learning
21 disability,"
22 until I could reflect that here were a group of 30 or
23 40 Eskimo children being taught in English, the curriculum
24 that was appropriate perhaps for a southern community
25 which was totally meaningless in the south, and I asked
26 the teacher if she put herself in the position of suddenly
27 finding herself in Japan being taught under these circum-
28 stances in Japanese, would she not appear like a learning
29 disability? I am sure that I would, so I don't think
30 there's any racism implied at all, because under these

Atcheson, Kehoe
Cross-Exam by Sigler

1 conditions we can see problems generated. The teacher
2 with her training in the south was saying, "I have a
3 group of disordered children, all of them have learning
4 disabilities. I want a psychiatrist to treat them."

5 The obvious fact had gone
6 unrecognized. Here was a circumstance where anyone would
7 have a learning disability. I don't think that's
8 racism, that's an objectivity that says, "Under these
9 conditions people react to stress."

10 Q So you're generalizing
11 not just about the native people or white people of
12 Frobisher Bay, but of the native people or the white
13 people of the entire north in some of the points that
14 are made in the paper?

15 A I would be generalizing
16 to the point that if you say, "Take a group of human
17 beings and put them under these circumstances, these
18 are the reactions you can predict."
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Atcheson, Kehoe
Cross-Exam by Sigler

1 Q In addition, there would
2 be special community problems or local individual
3 problems?

4 A Sometimes secondary to
5 this problem. This type of misidentification as a
6 result of that, then a lack of role and other problems
7 being generated as a result of that become very
8 individual. Every family in Frobisher Bay where the
9 father has lost his role as a traditional noble hunter
10 does not batter their children. There are individual
11 differences obviously that one must deal with in each
12 unit. But there are generalizations that one can make
13 concerning factors of stress.

14 Q Dr. Atcheson, in your
15 paper--at the conclusion of your paper you make a
16 strong plea for a new culture, "the new culture, the
17 new society in which the rights of all citizens are
18 held as sacred". Truly ideal goals. Are you suggesting
19 that development in the North be postponed until this
20 end is achieved or do you think that end will ever be
21 achieved?

22 A I make no apology for
23 that philosophy. I think if it isn't achieved, we're
24 on a road to destruction and I think that is precisely
25 the important issue of humanity today is to find a
26 way to deal with issues of this sort and I feel that
27 we are presented with an opportunity in the North to
28 find new ways and means of doing this that might indeed
29 contribute to the world.

30 Q Are you not calling for

a Utopia there in your last sentence?

A I see nothing undesirable
about looking at the stars sir.

Q Can you add any specific--
anything more specific to help achieve that Utopia?
How can that society be achieved in the North?

A I had hoped in the recommendation I made concerning a commission in which native people would in fact invite others to involve themselves in looking at new systems and with which they would contribute. I see this as one of the important areas. Certainly there isn't a school system in this country that is not at the present time under need of examination as to the validity of our educational process.

The problems we're looking at are not distinctly in the North.

Q You think that the native people of the North by being involved in such a commission will be able to set up a perfect society?

A Not a perfect one but a much better one that we have at present, sir.

Q And you're saying that that commission should be set up before there's any development?

A I think it's a priority. Indeed I do. I think that we can step in and do many, many things and then be beyond the point of return. We can be destructive and not be able to repair it.

Q So, you retain that

Atcheson, Kehoe
Cross-Exam by Sigler

1 idealism there that you would like to actually see that
2 goal worked on more?

3 A I retain that implicitly,
4 sir.

5 Q And I see you've kept
6 up that plea on a general plain. Could you extend that
7 to all of Canada, do you think? Why just the North
8 have you singled out for this plea?

9 A I can think of my own
10 constituency in Ontario and I think of the immense
11 amounts of money that have been spent recently on a
12 commission that is looking, for example, on the effect
13 of aggressive things on the television and I say surely
14 if we can afford commissions that examine what we
15 already know, we can afford commissions to examine what
16 we do not know.

17 Q How long do you see the
18 commission process taking or requiring?

19 A I would hope--

20 Q Do you see the hearings
21 of commissions going on forever in the North or do you
22 see them ever coming to an end?

23 A You ask a very difficult
24 question. I would say its tenure should exist until
25 we see improvement in the present conditions.

26 Q That could be forever,
27 I guess. Those are all the questions I have.

28 A If forever, then it's
29 valid.

30 MR. SCOTT: Mrs. MacQuarrie?

1
2 THE COMMISSIONER: Just before
3 Mrs. MacQuarrie goes ahead, the question Mr. Sigler
4 asked you, both of you, there are some words that are
5 used that people tend to want to be very careful about
6 the way they use them and race is one of those words.

7 But you have told us about the
8 impact that you, as professionals in your respective
9 fields, have seen arising from the impingement of one
10 race of people upon another. That's what happened and
11 the people of the Inuit race shared a common
12 heritage and culture and it is the impact on them as
13 individuals of what they, some of them at least,
14 perceive as a threat to that heritage and that culture
15 that has produced these individual symptoms.

16 Now, isn't it very difficult
17 to discuss the problem at all without making it plain,
18 this is what I understood to be the thrust of your
19 evidence and that it arises from the impingement of one
20 race of people upon another. You can't understand it
21 unless you go back to that, can you?

22 WITNESS KEHOE: Mr. Commissioner,
23 if I may respond to your talking about the use of the
24 word race. I would agree wholeheartedly and I thought
25 I went to some length in my report or my submission to
26 suggest that we're talking about values, a culture as
27 a set of values and I also, in my introduction, indicated
28 that I was talking about--for example, I mentioned the
29 Metis, I believe I did, that was what I had in mind
30 anyway; as a group of people who maybe even racially aren't

1 identifiable with the Athabascan Indians or the Inuit
2 but they're living a life style and it's the life style
3 that we're more concerned with, their life experiences
4 that either handicap them or assist them in making a
5 personal social adjustment that I'm concerned about.

6 I don't think it's a matter
7 of race.

8 THE COMMISSIONER: I see.
9 You're saying that it's what is going on in your head
10 that counts and if you identify yourself with that
11 particular group of people, with a particular heritage,
12 then to all intents and purposes, you're a member of
13 that group whether you happen to have the particular
14 mixture of blood in your veins that all of them do.

15 A famous English historian
16 said that anybody thinks he's a Jew is a Jew. That's
17 really what you're telling us.

18 MR. SIGLER:
19 There was one reference
20 in the paper of Dr. Abbott talking of the apartheid
21 policy where I believe the evidence was drafted along,
22 in the more commonly connoted sense of racial issues
23 that I just wanted, in my cross-examination for these
24 witnesses, to comment on it and I think their answers
25 did evolve into one of values rather than classes of
26 racial confrontation. A cultural thing rather than
a purely racial sense.

27 THE COMMISSIONER: I'm glad
28 you raised it the way you did and I'm glad you clarified
29 it in your last answer. I see your point. Okay.
30 Mrs. MacQuarrie, sorry.

CROSS-EXAMINATION BY MRS. MacQUARRIE:

Perhaps I'm not very clear about this point, both Dr. Atcheson and Mr. Kehoe, but if your paper had been presented to include both the whites and the various native people in the Territories, would your conclusions and recommendations have been different?

Q Well, I think I was referring particularly to what Mr. Kehoe had said at the conclusion of his paper. You seem to have generalized a great deal about the native people in the North and their mental health. Mr. Kehoe did say that his point of view was particularly biased because he was appearing for COPE. Now, my question is, if he had been appearing for the total population of the Territories, would his conclusions and recommendations have been different?

Atcheson, Kehoe
Cross-Exam by MacQuarrie

1 THE COMMISSIONER: If you had addressed
2 mental health of all residents of the Territories, of
3 all races, it would have been a longer paper, I guess.

4 A Well, I can
5 respond, Mrs. MacQuarrie, it wouldn't have been any
6 different. I see people living under these circumstances
7 and they're both being affected. If we consider that
8 the non-native Canadian person in the Eastern Arctic
9 is not affected by these changes, what is observed, we
10 would be wrong. I am equally concerned about the mental
11 health and psychiatric disorders in all fellow-Canadians,
12 not just some that come from a particular area.

13 WITNESS KEHOE: And if I may
14 comment. What we're doing is applying some general
15 principles of mental health psychiatry and psychology
16 through the problem of people living in the north and
17 those same principles would apply. I think you've
18 heard themes, I've heard you have heard themes on
19 previous days of this Commission, and will hear in
20 the future, of the importance of giving people respon-
21 sibility for themselves, giving people authority for
22 themselves, giving people opportunity to exercise
23 options, making them the primary beneficiaries of
24 development in the north. These principles apply not
25 only to the native people but to the whites also. They're
26 general principles that make for mental health, make
27 for a feeling of control over your own lives.

28 Q But you didn't answer my
29 question, Mr. Kehoe, about whether or not your conclu-
30 sions and recommendations would have been slightly

Atcheson, Kehoe
Cross-Exam by MacQuarrie

1 different?

2 A Do you have a specific
3 thing in mind, because what I'm saying is that the
4 general principles, I think, apply to all people.

5 Q All right.

6 A In fact, you'll notice
7 in my submission I made reference to a UNESCO study of
8 several years ago. These principles, as I pointed out
9 in my submission, seem to me to apply very well today,
10 but they didn't have Yellowknife in mind when they were
11 written. Yellowknife barely was when they were written,
12 and yet they apply, general principles of behaviour
13 and mental health.

14 MRS. MacQUARRIE: Thank you.

15 THE COMMISSIONER: They didn't
16 have Yellowknife in mind when they wrote this. That's
17 hard to believe.

18 MRS. MacQUARRIE: Q Dr. Atcheson,
19 could you describe the level of mental health services
20 that are provided to the residents of the Territories
21 by the Federal Government now?

22 WITNESS ATCHESON: I can only
23 speak to the Eastern Arctic, in which the group that
24 I have described in my presentation are the psychiatric
25 resource of the Eastern Canadian Arctic. I know less
26 of the organization. Dr. Abbott is in charge of
27 psychiatric services for northern medicine, and I think
28 is making every attempt to identify more services.
29 There are consultations that are made and have been made
30 in Winnipeg in the University of Manitoba, Dr. Rogers

1 and others in the Keewatin area. These are the only
2 ones I can speak to, as well as the good fortune of
3 having Dr. McKay as a psychiatrist in Yellowknife at
4 the present time, who is servicing, I understand, not
5 only Yellowknife but also seeing people in the delta
6 region and some of the other areas of the Western
7 Arctic. I feel incompetent to reply to Dr. Abbott's
8 plans for the future, and the prospects of improving or
9 increasing those services, but those are the identi-
0 fiable services at the moment.

Currently --

MRS. MacQUARRIE: Yes, I would.

A Myself, Dr. Samuel

Malcolmson, and Dr. Eric Hood have taken on this responsibility. We share it by identifying together, we make one trip a year which we take together in order that we may share our information about certain patients the other is treating. There is a continuity that on every trip one of those people will be there, so that the continuity with the people in Frobisher Bay and the services, the people know us and know we come back to me has been important. It's complemented by an arrangement

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C ross-Exam by MacQuarrie

1 with the University of Toronto which a senior resident
2 in the Department of Psychiatry accompanies us. This is
3 not only to give that resident a particular type of
4 experience in psychiatry, but hopefully to solicit his
5 interest in this type of practice in this part of our
6 Canadian scene. This was a very successful enterprise
7 because both Dr. Malcolmson and Dr. Hood were residents
8 that accompanied me in my early days. I am glad that
9 they are there to carry this work on.

10 Q In Frobisher Bay itself,
11 what on-the-ground services are there between visits?

12 A There are physicians
13 who practice in the hospital at Frobisher Bay. There
14 are those people in the Social Development Department,
15 in the Public Health Nursing, and in the school systems
16 with whom we can keep in contact around certain problems.
17 We have perhaps two to three telephone consultations
18 a month from people in various divisions of these
19 services that I mentioned.

20 I think more importantly is
21 the contact with those native Canadian people who have
22 arranged such things as the successful petition to
23 close the Liquor Store, and I also mentioned
24 the Juvenile Court Committee. We are invited to sit
25 with them to comment on their work, to put some input
26 into it, but by and large they are the 'primary therapists.

27 Q O.K. In terms of diagnosis
28 and treatment of someone who becomes mentally ill, or
29 disturbed in Frobisher Bay, can this be done there or
30 do they need to be seen by you in the south?

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Cross-Exam by MacQuarrie

1 A We have tried very hard
2 to maintain people where they live, and I think this
3 is reasonably successful. An anecdote, for example,
4 could be a patient that I saw some 2½ years ago in
5 one of the settlements, Cape Dorset, it was a particular
6 type of mental disorder that would respond to medication
7 and would respond to the helpful resource from the
8 Nursing Station to make sure that this type of medication
9 was maintained. On a subsequent follow-up visit a year
10 later or six months later, Dr. Malcolmson asked the
11 nurse if she would not wish that he see this patient
12 and review the program and treatment at the moment, and
13 we were both gratified by her statement, "She is doing
14 extremely well, I think it would be very disturbing if
15 you saw her. I'll call you if I need you."

16 I think this is the role of
17 the consultant, to leave information with the people,
18 whether it be the Nursing Station or whether it be the
19 person who is in charge of the Juvenile Court Committee,
20 that may in fact be used after one has left.

21 Q Is there a psychiatric,
22 community psychiatric nurse in Frobisher Bay now?

23 A Not at the present time.
24 There is -- Dr. Abbott has been trying to resource
25 this need; he has not been successful at the present
26 time.

27 Q There's a rapid turnover
28 of nursing staff in these communities. Do you not find
29 it difficult to have the follow-up and rehabilitation
30 of the mentally ill carried on?

Atcheson, Kehoe

Cross-Exam by MacQuarrie

A Indeed we do, and the

Q Would you say that the

A I would have no dispute

Atcheson, Kehoe
Cross-Exam by MacQuarrie

1 Q Mr. Kehoe, how do the
2 services to Frobisher Bay correspond to the mental
3 health services in the Yukon?

4 WITNESS KEHOE: Mental health
5 services in the Yukon are entirely the responsibility
6 of the pshchiatrist and myself, both members of
7 National Health and Welfare. We're both based in
8 Whitehorse. Our area^{of} responsibility is the Yukon
9 region which is the entire Yukon Territory.

10 THE COMMISSIONER: And both
11 of you are employed by Health and Welfare?

12 A National Health and
13 Welfare.

14 Q And is he the only
15 psychiatrist and are you the only psychologist in the
16 Yukon?

17 A He's the only psychiatrist
18 in the Territory. I'm the only psychologist in
19 National Health. There have been psychologists in the
20 educational field in recent years.

21 MRS. MACQUARRIE: Do you not
22 have support staff?

23 A No, we have no direct
24 support staff. However, as I mentioned earlier, we
25 take a community orientation and I prefer to work
26 through existing services and try to--in fact, it's
27 very much of an educational function on my part to improve
28 the existing services from a mental health point of
29 view.

30 Q And you feel satisfied that

Atcheson, Kehoe
Cross-Exam by MacQuarrie

1 this is the proper level of services that these people
2 should have?

3 A Well, I have to agree
4 here with Dr. Atcheson that as with most of Canada I
5 think we're short on service. In terms of the population,
6 just over 20,000 people in the Territory, you would
7 expect perhaps two psychiatrists to deal with that
8 size of population.

9 However, I'm not encouraging
10 a rapid development, empire building because
11 frankly I'm not sure which direction health services
12 should be going, except that I think it has to be
13 something that improves the ability of the people
14 who are most likely going to be the permanent residents
15 to deal with their health problems.

16 At this point, I haven't got
17 a program to really develop that. It's a direction
18 I'm looking though but I don't think it necessarily
19 improves things if I were to bring in or recommend that
20 other mental health professionals be brought in from
21 outside, which is what we'd have to do.

22 Q Well, can you see the
23 training of local people as paraprofessionals then?

24 A Yes.

25 Q Or lay counsellors, this
26 kind of thing?

27 A Yes, and they're used
28 that way. Informally as well as formally. Again, they're
29 not on our staff but I consult to a variety of
30 organizations that make use of counsellors of that sort.

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Cross-Exam by MacQuarrie

1 Q Is there a lay counselling
2 program in the Yukon then, an active one?

3 A There is one for education
4 which is just developing now. They've experimented
5 with home school liaison workers in previous times and
6 now they've developed a system of counsellors, about
7 a dozen people, who are just concluding training and
8 they'll be going to their respective communities. I
9 would, for example, work through them in dealing with
10 behavioural problems that were referred to me, where
11 they might have any influence on them.

12 There's the Indian Affairs
13 counsellors, of course. Social Welfare branch. The
14 other kinds of traditional services.

15 Q Dr. Atcheson, I think
16 it was 1969 or 1970 you published an article in
17 Canada's Mental Health predicting the increase in the
18 rate of suicide and juvenile delinquency. Do you
19 remember that article?

20 WITNESS ATCHESON: Yes, indeed
21 I do.

22 Q I wonder if you could tell
23 us a bit more about it and whether or not the predictions
24 you made at that time have in fact come about.

25 A I think the predictions--
26 I think I used some rhetoric on that particular article
27 in which I said unless some of these problems were
28 solved that Frobisher would become the Watts of the
29 North. Fortunately that has not happened, but there
30 certainly have been feelings of aggression that have

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Cross-Exam by MacQuarrie

1 been well demonstrated many times, both by non-native
2 Canadians and Canadian people towards each other.

3 The rate of suicide, I cannot
4 give you an accurate figure for the Frobisher area. It's
5 my opinion that it has increased and that the incidents
6 of violent behavior has increased as well, but I haven't
7 accurate epidemiological data.

8 Q Well, even five years
9 ago you were alarmed at the tremendous increase in the
10 suicide rate in that part of Canada.

11 A I was very alarmed at
12 it, yes.

13 Q I'm sorry that Dr. Abbott
14 isn't here because I wondered about the cost of the
15 present mental health delivery in the Northwest
16 Territories. Do you have any idea of how much Federal
17 money goes into supporting that particular area of
18 health?

19 A I haven't that information
20 for you.

21 MR. BAYLY: Again, Mr.
22 Commissioner, we can put that question to Dr. Abbott
23 and ask him for a written reply if that satisfied Mrs.
24 MacQuarrie's question.

25 MRS. MACQUARRIE: Also, our
26 association would be very interested in the long-range
27 / plans of the department for the provision of mental health
28 services. I was going to ask that of Dr. Abbott today
29 as well.
30

MR. BAYLY: We'll put that one

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Cross-Exam by MacQuarrie

1 to him as well, sir.

2 MRS. MACQUARRIE: Dr. Atcheson,
3 the patients who are not--the mentally ill people that
4 are not able to be treated in the North are sent to
5 southern mental hospitals. Is that correct?

6 A There are some, yes.

7 Q Would you know offhand
8 the approximate length of stay in these hospitals and
9 also whether or not the staff in the southern mental
10 hospitals is well prepared to deal with native northern
11 people?

12 A I would think the direct
13 answer to your question is that staff in a southern
14 psychiatric facility are not well prepared to handle
15 the problems of native people.

16 It is infrequent. I cannot
17 give you an actual, again accurate data in which
18 mentally disturbed people would be moved to the south
19 at the present time. It would be my opinion that it
20 would be most valuable if a setting, where adequate
21 interpreters were available, where there were some
22 familiar cultural surroundings, could be achieved for
23 those who might need hospitalization for a period of
24 time could be dealt with.

25 I would, however, favor and
26 have always felt so that the mentally ill persons be
27 dealt with where they are and I would see no reason
28 why within the existing hospital facilities in the
29 Territories that in the same way as we treat the
30 majority of psychiatric people in general hospitals at

1 the present time, that with adequate psychiatric nursing
2 and consultation, that the majority, indeed the majority
3 of mentally ill people could be treated in the community
4 in which they live. You could not reduplicate hospital
5 facilities of that sort in each settlement in Baffin
6 land. That is obviously not appropriate, but at least
7 to use Frobisher in that area as a center where there
8 are familiar cultural characteristics, language
9 difficulties do not exist, would be in my opinion more
10 appropriate. I do not favor admitting people to a
11 southern hospital from the northern communities.

12 We recently admitted a native
13 Canadian person to the Clarke Institute where I am on
14 the staff and it was for a particular type of assessment.
15 There were forensic issues involved. A court was
16 requesting this examination and the conditions of the
17 admission were that an interpreter accompany the person
18 and remain with them for the entire period of hos-
19 pitalization. This proved to be quite a satisfactory
20 method. The interpreter had been trained in Ottawa,
21 was familiar and comfortable in Toronto, had friends
22 there with whom she could live, spent the day in the
23 hospital with the patient and with our staff in working
24 the problem through. A very expensive procedure but
25 the only appropriate way that I could suggest giving
26 an appropriate opinion to the court.

27 Q I understand that the
28 Federal Government does not hire psychiatric nurses
29 in the Northwest Territories. Are you aware of that
30 at all?

1 A I was not aware that this
2 was a specified policy. I am aware that Dr. Abbott has
3 been trying to hire a psychiatric nurse with community
4 experience to act as a liaison person between this
5 consulting team and the resources in Frobisher.

6 Q This would be a registered
7 nurse with psychiatric nursing?

8 A That's true.

9 Q Yes, but the psychiatric
10 nurse that does not have the background in general
11 nursing as a registered nurse is not able to be
12 employed in the Northwest Territories. This had caused
13 a great deal of difficulty with some of the resident
14 psychiatric nurses who would very much like to work
15 in that capacity for the Federal Government. Do you
16 know of any plans in the future to change that policy?

17 A I would have to leave
18 the response of that to Dr. Abbott.

19 Q I see.

20 MR. BAYLY: We'll pass that
21 on to him, Mr. Commissioner.

22 MRS. MACQUARRIE: Those are all
23 the questions.

24 THE COMMISSIONER: Maybe, Mr.
25 Scott, we could take a break for coffee.

26 MR. SCOTT: Sure.

27 THE COMMISSIONER: We'll just
28 stop for coffee for a few minutes.

29 (PROCEEDINGS ADJOURNED FOR A FEW MINUTES)

Atcheson, Kehoe
Cross-Exam by Steeves

(PROCEEDINGS RESUMED PURSUANT TO ADJOURNMENT)

MR. SCOTT: Mr. McLachlan, have you got any questions?

MR. McLAHLAN: No questions.

MR. SCOTT: Mr. Steeves?

CROSS-EXAMINATION BY MR. STEEVES:

Q You spoke of the necessity about people having a measure of control over their own destiny and I wonder if, given the present political state of the north, you have found any evidence of psychiatric disorders amongst the people that have come in from the south, some of them perhaps their ancestors of two or three generations ago come in from the south and have been faced with the present political situation in the Yukon or the Northwest Territories? Are there any psychiatric disorders that you've noticed associated with that, or to which that situation has contributed?

WITNESS KEHOE: Offhand no, I have to say no, not in any direct way. I think it would be kind of unlikely that that would occur because of the remoteness of this problem of direct personal control in the political sense. I think the options that are available to us as residents of the north now, while they might not be ideal, are not working any very serious hardship on us. I'm speaking for myself. I know others might not feel the same way.

Q All right. I'm not speaking now about people who are members of the bureaucracy or civil service, who have come in with the sure knowledge

Atcheson, Kehoe
Cross-Exam by Steeves

1 that they're going out again soon. I'm talking about
2 people who came to the north, some of them many years
3 ago, searching for a life style separate, different,
4 and distinct from that in the south, and who are now
5 faced or have encountered development. What's happened
6 to them or do you know?

7 A Well, some of them -- I'm
8 thinking of the Yukon, my experience in the Yukon, and
9 there are some who have certainly have become characters
10 in the town, for example. They've become marginal
11 residents. I'm thinking now of a fairly small group of
12 people who have simply failed to make that kind of
13 adjustment. They came in most often during the war when
14 development of Whitehorse was at its peak and stayed.
15 They usually had skills at that time that made them
16 employable. A lot of these people, though, become Skid
17 Row types in the Community of Whitehorse, as Whitehorse
18 grew.

19 Q Well, what's the process
20 whereby those people that have made that adjustment
21 -- and you know the kind of people we're talking about --
22 what's the process of making that adjustment?

23 A Are you talking about
24 the process of succeeding in making the adjustment?

25 Q In making the adjustment
26 to development, and many of them, that's the thing they
27 ran away from.

28 A I'm not sure, I 'm having
29 difficulty with your question. It's very hypothetical.
30 The kind of principles I talked about are relevant, the

Atcheson, Kehoe
Cross-Exam by Steeves

1 ability to perform functions that are relevant to them,
2 functions for which they are rewarded by their peers,
3 by relatives and so on, these will be important for
4 them to encourage them to take part in the community,
5 take part in the changes that are taking place in the
6 community. That would be conducive, I think, to their
7 health.

8 Q All right, thanks very
9 much. Dr. Atcheson, on page 5 of your paper, the first
10 paragraph, you take care there to emphasize that the
11 particular area with which you are most familiar in
12 the north, that is the Eastern Arctic, and the centre
13 of that particular area, Frobisher Bay, has no apparent
14 economic base. Is that a very significant factor in
15 the state of the mental health of the people at Frobisher
16 Bay?

17 WITNESS ATCHESON: I would have
18 to concede that it is, yes. I think an economic base
19 is important for the mental health of people. An economic
20 base can have a lot of different characteristics and I
21 think the characteristics of that base are important
22 to examine.

23 Q Is there a particular
24 kind of or group of kinds of economic activity that what
25 you've just stated applies to, or can you talk about it
26 in a general way? Economic activity ' occupying
27 part of one's life in a way which makes a return in
28 material goods.

29 A It's more than material
30 goods, in my opinion, sir. It is the role and the

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Cross-Exam by Steeves

1 satisfaction that one achieves by whatever service you
2 render and whatever its purpose is seen as being. The
3 respect and obvious self-image of importance that in
4 the previous hunting economy that a man would have in
5 bringing in the food for his family is hard to re-dupli-
6 cate the same significance by bringing in a cheque which
7 mother then purchases food from the local super-market.
8 I think it's hard for children under these circumstances
9 to make that transition and see that's equally important,
10 that that is a way of life. I think it's in the transition
11 of that format that the difficulty occurs.

12 Q I see. In terms of events
13 in the delta, what the aspirations of young people in
14 the Inuit communities and related areas -- we've heard
15 here the expression, we've heard a question that these
16 people have crossed the Rubicon and opinions have been
17 given that in fact they have, that many of the young
18 people have crossed the Rubicon so far as whether they
19 want to go to the bush or go back to the so-called
20 traditional way, or they want to move over and become
21 much more involved, not to the exclusion of the bush
22 but much more involved in the wage economy. Now, that's
23 the experience of not all, but some of the people who
24 observed the situation in the delta. I notice in your
25 paper that you state, in your opinion the people that
26 you've got to know as a result of your medical service
27 in the north have in fact crossed the Rubicon, so far as
28 the traditional way of life is concerned. Am I stating
29 it fairly?

30 A Yes, indeed, sir, and I

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1 appreciate your rhetoric in the term "crossed the
2 Rubicon". I think it's what they discovered on the
3 other side of the river. I think unfortunately that
4 some of the training process of helping that person
5 to cross the Rubicon, to become a part of this wage-
6 earning economy has been less than satisfactory. A brief
7 course of six months to train somebody to be a steno-
8 grapher, it makes it very difficult to compete with
9 somebody who has a two years Community College course.
10 To have somebody trained to do superficialities of
11 plumbing, versus a man who has or a person who has four
12 years of apprenticeship, they are not in a comparative
13 structure. So that in crossing the Rubicon, I would
14 only say that I hope they cross and they land at the
15 same landing.

16 Q Well, I'm interested in
17 the idea of your commission. I mean, implicit in that
18 it seems to me is this proposition, that the people
19 we're talking about and you understand I'm talking
20 about everybody who has a commitment to the north,
21 whether he be called native or Metis or whatever --

22 A yes sir.

23 Q -- the people we're
24 talking about don't need the existing bureaucracy or
25 any addition to it, to tell them what they should do
26 when they get to the other side of the Rubicon. Do I
27 understand you correctly?

28 A I don't think I understand
29 you correctly, sir. I didn't quite --

30 Q You made the point that

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Cross-Exam by Steeves

1 you hope when these people start -- the people we're
2 talking about -- start moving, I think we're using the
3 analogy on the Rubicon up the bank; do you follow me?

4 A Yes.

5 Q That they find what
6 they need is sort of some sort of meaningful role
7 for themselves in their family and in their community,
8 in a way that's incidentally economically rewarding. Is
9 that fair?

10 A It's my opinion that this
11 has not happened.

12 Q It's not happened?

13 A That's my opinion.

14 Q O.K. Now, what is the
15 commission that you've suggested? What has this
16 commission to do? Is it to work on that particular
17 problem?

18 A That would be one of
19 many issues that it might examine in depth.

20 Q Now, I tried to pick a
21 thread out of what I heard you say, and I'm not sure
22 it's there. Do you say that the existing system of
23 delivery of southern social services, be whatever they
24 are, has failed the people of the north?

1 A I believe so, yes.

2 Q Do you say that southern
3 techniques are ineffective in dealing with the people
4 problems in the North as a generalization?

5 A There are techniques of
6 education. There are techniques of treating people
7 who are sick that have universal applications. You
8 must apply them with a sensitivity to that person's want,
9 how they see these services, whether they desire them
10 These must be taken into account and I think it's in
11 that area that we have not discovered--I think we have
12 not discovered how to use our techniques appropriately
13 for the welfare of the people.

14 Q When you say the people,
15 you're talking not about the people of Canada as a
16 whole?

17 A I'm talking of people in
18 Canada as a whole as a matter of fact, because we are
19 addressing ourselves in many provinces to new methods
20 of health delivery, new methods of education and I'm
21 sure if we were satisfied with what exists, we would
22 not be doing that. I think this has application
23 throughout our country. I think it has specific and
24 unique application in a northern community.

25 Q Mr. Sigler--I'm going to
26 turn to something else now. Mr. Sigler was asking you
27 about the relationship between development and this
28 process that you see the people of the North have to
29 go through in order to reach some new basis for social
30 stability. I wasn't quite sure what your answer was and

Atcheson, Kehoe
Cross-Exam by Steeves

1 can I explore that with you by putting something from
2 Dr. Abbott's paper to you, which you've read, and I'm
3 sorry I don't have a page on mine but it's recommendation
4 two which, if you'll start at the back--some of my pages
5 have numbers and some don't.

6 You see recommendations for
7 future development in the North.

8 A Yes, sir.

9 Q Do you have that sir?

10 A Yes, sir.

11 Q I'm thinking particularly
12 of recommendation two. Well, I'm sorry. That's not
13 fair. It's not really a recommendation. The
14 recommendation is found at the top of the page and
15 he makes some points about that recommendation and
16 I'm particularly interested in point two.

17 "It is difficult to see how the
18 topic of native land claims could be dealt with in
19 isolation from planned development. The two topics
20 must obviously be dealt with simultaneously."

21 In the sense of the subject
22 that we've been discussing here today, do you agree
23 with that statement by Dr. Abbott?

24 A Not totally sir, no.

25 Q Okay. Do you understand
26 what he's trying to express there and I'm sorry to put
27 that to you but--

28 A It's my opinion that he's
29 trying to identify some priorities.

30 Q Yes.

1 A I think he is suggesting
2 that both planned development and the topic of native
3 land claims must be dealt with simultaneously. I would
4 not agree with that issue. We have imposed, if you will
5 or we have brought to this part of our country our
6 system of law which is based in the sanctity of owner-
7 ship and we have placed it on a culture that's talked
8 of our land and our people and the concept of ownership
9 was a distant one.

10 If we believe that our
11 philosophy is more appropriate than the first one, then
12 I suggest that we make our belief felt.

13 Q I'm not quite sure I
14 understand. Perhaps the difficulty here is native
15 land claims. What do you understand is meant by Dr.
16 Abbott when he uses that expression? Do you understand
17 it to be limited to the claim of what the lawyers call
18 aboriginal title which is being forward by people in the
19 North?

20 A I think that would be
21 what he's referring to.

22 Q And you don't--he's
23 clearly not referring to, for example, the political
24 aspirations of the people; the self-determination
25 aspirations of the people that we've heard about in
26 evidence here. Am I correct in that?

27 A I feel that the two would
28 perhaps be equated. If one had the resources, then one
29 can afford to be politically independent. There's a
30 resource phenomena which permits the person to enter into

Atcheson, Kehoe
Cross-Exam by Steeves

1 the political arena.

2 Q If I may say so, exactly.
3 I don't want to get into one of these silly discussions
4 about which came first. It seems to me that that's
5 a true proposition expressed here by Dr. Abbott and I
6 don't follow your disagreement. I don't understand
7 how you can do what you say this commission ought to do,
8 as I understand it, without at the same time having the
9 commission involved with development, economic development.

10 I don't understand how, in the
11 absence of economic development, you can deal with the
12 situation which we've agreed to describe as crossing
13 of the Rubicon.

14 A I think one has to give
15 a demonstration of more than good faith and I think,
16 in fact, that native Canadian people could very--with
17 great validity lay claim that over centuries, over a
18 period of history, they have not been treated honourably
19 and I think we are looking for--I am looking that our
20 country take a position in which we state that we
21 really mean it when we say that ownership is important.
22 Let's identify your stake in that. Let us clear that
23 up and then let's move forward together in some form
24 of development.

25 Q I understand what you're
26 saying. Dealing with the land claim issue, the bare
27 land claim issue quickly and amongst other things as a
28 token of good faith?

29 A Indeed, sir.

30 Q And then get on with the

1 other business which I sense from the commission idea
2 and everything else you've said is going to take a
3 long time and a lot of patience and a lot of commitment
4 on both sides.

5 A I would believe so, yes
6 sir.

7 Q Do you know anything about
8 the demographics of the eastern Arctic? I understand
9 demographics ^{to} mean population statistics and nothing more
10 than that.

11 A Not with accuracy, no.

12 Q Do you have any opinion
13 as to whether or not the population of the eastern
14 Arctic, and I'm talking here about all the people in
15 the eastern Arctic, contains an unusually high number
16 of young people.

17 A Yes, it would.

18 Q And again there, these
19 young people have been exposed to the influences in the
20 school system?

21 A Yes, sir.

22 Q What specific recommen-
23 dations would you make to Arctic Gas if you were told
24 that Arctic Gas wanted to provide--I'm sorry. Is there
25 somebody saying something? I thought I heard somebody
26 speaking.

27 If you were told that Arctic
28 Gas wanted to provide the economic activity that you
29 have said is absent in Frobisher Bay and wanted to do
30 it in a way that was meaningful to the native people,

Atcheson, Kehoe
Cross-Exam by Steeves

1 not in southern form, but in a way which would help
2 these people when they climb the bank across the
3 Rubicon.

4 A I have difficulty sir
5 answering that and it's not an evasion on my part. It's
6 a puzzlement really. It seems to me that I cannot
7 identify that role for Arctic Gas. I have to identify
8 it for the Government of Canada, for the citizens of
9 Canada, of which Arctic Gas is a corporate entity.

10 I cannot really identify that
11 in my own mind clearly.

12 Q You mean you reject any
13 leadership role by Arctic Gas in that particular area?

14 A With the exception of
15 well-structured foundations, such as the Rockefeller
16 et cetera, I distrust sometimes industries role in the
17 humanities.

18 Q I'm sorry. You just won't
19 accept my assumption.

20 A I have difficulty accepting
21 your assumption sir, yes.

22 Q Can you tell me the answer
23 and be good enough to accept the assumption?

24 A Well, all I can identify
25 with is the contribution of Arctic Gas and I may be
26 completely wrong because I don't understand its
27 corporate structure; would be that it would have
28 available funds that it might resource some type of
29 operation, that it might provide a source of funding
30 of some of the services that the people might wish to

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Cross-Exam by Steeves

1 develop.

2 THE COMMISSIONER: Suppose you're
3 called upon to advise the Rockefeller Foundation if it
4 were willing to do whatever was appropriate and leave
5 Arctic Gas out of it for the moment. What would your
6 view be?

7 A If the government would
8 permit, I would suggest they subsidize this commission
9 I recommend as the first step. The government might
10 not permit it.

Atcheson, Kehoe
Cross-Exam by Steeves

1 THE COMMISSIONER: You didn't
2 get very far with that one.

3 MR. STEEVES: I think
4 I know where we go from there, and I'm --

5 THE COMMISSIONER: Pardon me?

6 MR. STEEVES: I say I think I
7 know where we go from there, and I'll just look at my
8 notes.

9 Q Is it your opinion that
10 some, any significant act of good faith will have
11 immediate and positive beneficial effects for the
12 problems of northern people you're talking about now?

13 A An act of good faith
14 on the part of whom, sir?

15 Q On the part of the
16 Government of Canada or of the -- on the part of the
17 Government of Canada.

18 A Yes sir, I think that
19 appropriately settling the native land claims is a
20 priority, and I think that is an act of good faith.

21 Q Well, I understand that.
22 I'm asking if any act of good faith will serve the
23 same purpose, or do you have to specify in your recommen-
24 dations the settlement of the land claims?

25 A I specify that with
26 priority.

27 Q Well, would you tell me
28 why?

29 A I've tried in a philosophi-
30 cal sense to, sir. I don't know whether I can document

Atcheson, Kehoe
Cross-Exam by Steeves

1 it more carefully, my feelings. I feel there is a just
2 claim and I feel that our system of justice deals with
3 just claims appropriately, and this one should therefore
4 be dealt with in that way; and if that does not happen,
5 then if I were a native Canadian person, I would dis-
6 trust my government, I would distrust those people who
7 tell me these are acts of good faith.

8 Q But that's not the only
9 just claim the native people have. Many people have a
10 just claim to some sort of self-government within at
11 least some limited form of self-government within
12 Canada, do they not?

13 A I would hope that all
14 Canadian people would participate in our political
15 system with equal rights, would have the appropriate
16 vote to make their feelings felt, and they enter into
17 that political arena with understanding. I don't think
18 it is a question of, in my opinion, seeking some
19 independence beyond the independence that provinces
20 seek and municipalities seek and the communities seek.
21 But beyond that, they're part of the greater constituency
22 of our country.

23 THE COMMISSIONER: I don't
24 think Mr. Steeves was getting at that. Native people
25 that ^{have} addressed this Inquiry, they put a broad construction
26 on the phrase "land claims", just like 'mental health
27 that has a broad connotation, and it includes not simply
28 a claim to the land, as I understand it, but a claim to
29 a measure of control of the schooling of their children,
30 the right to community-based economy, development based

Atcheson, Kehoe
C ross-Exam by Steeves

1 on renewable resources and to share in non-renewable
2 resources, and none of these things are spelled out
3 as explicitly as you and I might like them to be, but
4 some measure of self-government. So as I understand,
5 Mr. Steeves is saying, "Why do you put simply a claim
6 to the land itself ahead of these other things?"

7 I'm probably not being helpful
8 at all by intervening.

9 A Well, I guess I put
10 such priority on it, sir, because again as I examined
11 history, we have made articles of faith and we have not
12 upheld them, and I would like to see this one upheld with
13 priority so that the people are not going to discover
14 20 years from now it wasn't upheld, but the operation is
15 going on with this conviction. My point in response
16 to this broader concept of land claims and rights,
17 the right for education, the right for health services,
18 I'm only stating in my recommendations that the native
19 Canadian person have an input into that, they have
20 the right to make differences in the same way as in our
21 political system in any community, we have the right to
22 do certain things about our local School Board. But
23 the province on top of that lays certain issues on top
24 of that, but in fact that they be allowed to participate
25 in their own development, in their own schemes of service.
26 I think that's an article of faith.

27 MR. STEEVES: Thank you. That's
28 all I have.

29 THE COMMISSIONER: Thank you,
30 Mr. Steeves.

Atcheson, Kehoe
Cross-Exam by Scott

1 MR. SCOTT: I just have one
2 or two questions.
3

4 CROSS-EXAMINATION BY MR. SCOTT:

5 Q First of all, tell me if
6 I understand correctly here what I took to be the thrust
7 of your papers, and the thrust of your answers to Mrs.
8 MacQuarrie, and that's first of all that you lay -- that
9 you regard as important, that you lay less stress on
10 the necessity for the provision of psychiatric hospitals,
11 support services and doctors and nurses and so on, which
12 really is only going to treat the clinical cases by and
13 large, and that the solution to the mental health problem
14 that will be created by the impact of development in
15 the north is a long-term solution. Do I have that
16 right?

17 A From my point of view,
18 yes sir.

19 WITNESS KEHOE: Yes, I'd agree
20 with that. I think the distinction, although it's a
21 relative matter, I would expect that there would have
22 to be an increase in direct treatment services in
23 proportion and perhaps even greater in proportion
24 to the population increase during that period of time.
25 But I would think the long-term solutions will be found
26 in indirect services and prevention.

27 Q And would I have it right
28 for both of you if I summarized it by saying it this
29 way, that the long-term solution depends on fundamentally
30 on supporting the ability if we're speaking of native

1 people now, supporting the ability of native people
2 to make their own social and political adjustment against
3 a planned and orderly development project, and that's
4 why Dr. Atcheson, for example, sees his commission as
5 an aid in that process and his petitioning force in
6 Frobisher Bay as another kind of aid. Do I have that
7 right?

8 WITNESS ATCHESON: From my
9 point of view, yes sir.

10 Q And psychiatric support
11 staff in that process really perform a sort of consult-
12 ive or resource role rather than a leadership role.

13 A Yes sir, and then I make
14 the additional responsibility of my profession to
15 deal with mental illness that we can diagnose and deal
16 with and classify. I think that's a responsibility that
17 I have as well.

18 Q But that's the clinical
19 cases sort of on top.

20 A That's right, sir.

21 Q Obviously psychiatrists
22 have to deal with those who are mentally ill first of
23 all, but the road to mental health, as you see it, both
24 in the Northwest Territories, lies in the development
25 of this kind of self-adjustment against a planned
26 incursion from the south.

27 A Yes sir.

28 Q Supported by psychiatric
29 and other facilities.

30 A Yes sir.

Atcheson, Kehoe
Cross-Exam by Scott

1 Q Yes, all right. Now let
2 me put another proposition to you. Let us assume for
3 the moment that a pipeline project is going to be
4 constructed in the Mackenzie Valley either commencing
5 in five years or commencing in ten years, and that
6 with it will come a sequence of developments, another
7 gas pipeline, an oil pipeline, a highway, and perhaps
8 a railroad, over a period of the succeeding 10 or 15
9 years from the start of construction. Do you have
10 that scenario in your mind?

11 A Yes sir.

12 Q All right. Now let's
13 leave aside for the moment, because we have your view
14 on it, the necessity of dealing with land claims, and
15 let us leave aside for the moment the importance of
16 some such commission as you envisage, Dr. Atcheson.
17 I'd like you to tell me in point form to begin with
18 what you think the things that should be done are in
19 the five to ten years of lead time that are available?

20 A I would think certainly
21 that the ecological protection and so forth must
22 go without saying as being necessary, and I'm aware that
23 this Commission has addressed that issue many times.
24 I would feel that the -- we should be in fact preparing
25 professional and paraprofessional people and assisting
26 the native people, assuming they did have this commission
27 which could delineate needs and types of systems, that
28 every preparation should be made to train, instruct,
29 and deal with those persons. I would think that edu-
30 cation of those who wished to enter into the educational

Atcheson, Kehoe
Cross-Exam by Scott

1 stream and be prepared to accept responsible positions
2 in this developing economy of this corridor that you've
3 described , that they be prepared for it now and that
4 there be a preparation that leads for sort of an equal
5 rights situation, not a partial training but training
6 that would lead to positions of leadership in that
7 operation.

Atcheson, Kehoe
Cross-Exam by Scott

1 Q Mr. Kehoe, if you want
2 to add anything, feel free.

3 WITNESS KEHOE: Yes, if I understood,
4 Mr. Scott, you excluded the possibility of the commission
5 that Dr. Atcheson was suggesting --

6 Q No, I simply say that
7 we have Dr. Atcheson's view which, I take it, you share
8 about that kind of process and so we may take that as
9 given for the moment. What else?

10 A The only thing I would
11 add to what Dr. Atcheson has suggested is something
12 that would be akin to the commission which he's
13 suggesting which would be an interdisciplinary team
14 involving people in the various social sciences,
15 including economics and so on and the community leaders
16 to try to anticipate just as we have here today,
17 try to anticipate the problems that they are going to
18 be faced with and arrive at strategies for dealing with
19 it, taking development as a potential problem for that
20 community.

21 Q Well, absent the
22 commission just for a moment. Under whose
23 would that process be run? Is that something government
24 can do or is it not in your judgment?

25 A I think it's a
26 responsibility of government to do it, whether or not
27 they can do it well because--

28 Q I didn't mean to ask you
29 to comment on whether they had the will or
30 capacity to do it. Is that something that government

Atcheson, Kehoe
Cross-Exam by Scott

1 should legitimately be doing or is it something that
2 should be sponsored in some other fashion?

3 A I find it difficult to
4 make a comment on that.

5 Q Well, do you have anything
6 else to add to the list?

7 A I'm not sure what your
8 question is asking. It would be ideal if the initiative
9 and the structure came from the community to deal with
10 that problem. Chances are that won't happen, in which
11 case somebody has to activate it. There has to be
12 somebody to initiate it and most likely that would be
13 a government agency. Is that to the point?

14 Q I understand your answer.
15 Are there any other things that you think have to be
16 done in the next five to ten years if this project
17 goes ahead to enable us to effectively respond to it.

18 A At the moment I can't
19 add anymore but I'd hate to indicate a no on my part.
20 I think with further thinking--in fact, we're going to
21 have to do further thinking because development generally
22 let alone any rapid development through pipeline
23 construction.

24 Q Well, don't feel yourself
25 constrained by the hearing process. If you think there
26 are other things that should be done, you write us,
27 either of you, and let us know and we'll make your
28 letters available to the other participants. When the
29 recommendations are made I wouldn't want any of you to
30 be avoided, to be saying to yourself, gee, I wish we'd

1 suggested this or suggested that because this is really
2 your opportunity to do so.

3 Now, in connection with the
4 suggestion that Dr. Abbott made, I'd ask you to turn,
5 both of you if you wouldn't mind, and we'll see if we
6 can deal with it in his absence, to page two of the
7 summary of recommendations at the end. In paragraph
8 five of that summary, he comments and we've heard these
9 comments from other panels about the unfortunate
10 consequences that sometimes exist if you inject a large
11 amount of wage employment, money, into a small community
12 which isn't used to it. He says,

13 "Methods should perhaps be explored of alternate
14 means of employment and payment".

15 Now, I wonder if either of
16 you have given any thought to that or have any sense
17 of what might be implicit in that observation. What
18 other methods should be examined?

19 A I would suggest that one
20 possibility is the proposal of the Council for Yukon
21 Indians which is to make the pipeline construction a
22 public company, in which various participants would
23 hold different shares. The specific suggestion was for
24 majority shares to the native people themselves. Minority
25 shares to other Canadian citizens; to the company itself
26 and to the Canadian Government.

27 This might be one alternative
28 to simply hiring people on the spot.

29 THE COMMISSIONER: Mr. Bayly,
30 maybe you, in a letter to Dr. Abbott, would ask him to

Atcheson, Kehoe
Cross-Exam by Scott

1 enlarge upon that notion.

2 MR. BAYLY: Yes sir. We'll
3 put that into our letter to him.

4 MR. SCOTT: Dr. Atcheson, at
5 this time, do you have any comment?

6 WITNESS ATCHESON: I don't
7 sir.

8 Q I should tell you one
9 thing and perhaps Mr. Bayly has advised you of this;
10 there has been a good deal of evidence at the Inquiry
11 about the desirability, I think even the undesirability
12 looked at from another point of view, of the pipeline
13 project hiring persons in the community to do either
14 skilled or unskilled work on the project and there's
15 been further discussion about various modes of assuring
16 that that is achieved. That is by on-the-job training,
17 by training in centers outside of the communities and
18 even in the South and other methods such as quota
19 systems and so on.

20 Now, presumably if the project
21 goes ahead, some decisions are going to have to be
22 taken about those various schemes, about the whole
23 question of principle first of all, whether northerners
24 should be employed and in what kind of capacity and
25 how they should be trained and secondly, the question
26 of practice, how these things are going to be achieved
27 through quotas or otherwise and I wonder if from the
28 point of view of your disciplines, you've had an
29 opportunity to give any thought to these questions or
30 formed any conclusions as to the best approach to this

Atcheson, Kehoe
Cross-Exam by Scott

1 kind of problem?

2 A I don't think sir, that
3 I can respond by describing what I think would be an
4 appropriate approach. I think that is one of the
5 things I think needs research of educators and the
6 native Canadian people and others.

7 I think we might profit from
8 some of our errors. I think the system of removing
9 children from where they live with their parents to
10 a distant scene to live for long periods of time and
11 somewhat a familiar environment for training is an
12 unsatisfactory one.

13 I realize that hostiles for
14 training of children in the North has perhaps been a
15 necessary evil. I suggest there be no more evil than
16 necessary and if in fact we could remove ourself from
17 it, that we do so. So, somehow again is the implicit
18 need of maintaining the family together, of allowing
19 that training to happen where contact can be made.
20 I think this is one of the important issues I would see.
21 To address yourself as to how that be done is something
22 that I would not feel confident to do at the moment,
23 sir.

24 Q Mr. Kehoe?

25 WITNESS KEHOE: I'm afraid
26 I would have to echo Dr. Atcheson's comments. I think
27 this is on the periphery of my experience. I'm
28 familiar with some of the problems but I don't think
29 I would make a judgment one way or the other with regard
30 to the training.

Atcheson, Kehoe
Cross-Exam by Scott

1 Q If in the future you've
2 an opportunity to think about it and form some con-
3 clusions, I'd be grateful because some of the evidence
4 we've had poses this dilemma. First of all, the
5 communities as they exist must be preserved and their
6 viability maintained and that requires having the
7 young men of those communities of the older men living
8 in them for at least substantial periods of time as
9 they do now. Everybody says that that is an important--
10 or I shouldn't say everybody but most people say that's
11 an important consideration.

12 On the other hand, most people
13 say it's an important consideration. If the project
14 was to go ahead, that the native people should get
15 responsible positions of leadership in the project and
16 I think that there's an inherent conflict or there
17 may be a conflict in those two propositions. There may,
18 on the other hand, be a way of resolving them both and
19 if you have any views about that, I'd be grateful to
20 hear them, either now or as I say by letter later if
21 you have an opportunity to think about it.

22 WITNESS ATCHESON: Thank you,
23 sir.

24 MR. SCOTT: Those are all the
25 questions I have. Thank you, Mr. Commissioner.

26 THE COMMISSIONER: Any re-
27 examination?

28 MR. BAYLY: No, sir.

29 THE COMMISSIONER: Mr. Kehoe,
30 just one thing here. You said at page-- that some of

1 your colleagues take the view that virtually all of the
2 native people are subject--oh here it is on page two.
3 You say--oh, I'm trying to find it
4 then I'll ask you about it.
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Atcheson, Kehoe

1 You referred on page 3 to
2 a statement by Hellon a Canadian psychiatrist, that
3 behavioural deviance is becoming a cultural norm amongst
4 the native peoples. He was referring to those types of
5 behaviour disorders which, while not conforming exactly
6 to our psychiatric diagnostic categories do impair
7 development, physical health and social adjustment and
8 which mitigate against the realization of full human
9 potential happiness, and I think that later on you
10 were referring to the same thing when you said at
11 page 12, you said -- you referred to passivity, loss
12 of interest, decrease in energy, difficulty in concen-
13 tration, lack of motivation and ambition, and a feeling
14 of helplessness.

15 "It has been suggested by many of my colleagues
16 in psychology, in psychiatry that this disorder
17 is virtually endemic among the northern native
18 people."

19 Now, in the earlier reference you meant this range
20 of symptoms that you described from passivity to a
21 feeling of helplessness. I got you there, that's all
22 part of the same picture. Then you said,

23 "This disorder is virtually endemic among the
24 northern native people, but at a sub-clinical
25 level, or it perhaps simply goes unrecognized
26 as depression."

27 You told us what a sub-clinical level meant, but what
28 did you mean? I've forgotten.

29 WITNESS KEHOE: Referring to
30 the fact that these disorders, if they exist, and I am

Atcheson, Kehoe

1 saying that I necessarily agree with this.

2 Q Yes.

3 A These are things that
4 have been suggested before which just indicate the
5 feelings of others, but these are behaviours that exist
6 in a community in fairly large -- in a fairly high
7 degree of prevalence, but don't become recognized or
8 noted as mental illness, as psychiatric disorders, there-
9 fore there would be no referral to a visiting psychiatric
10 team, for example. I suggest something that would
11 be more familiar perhaps is the common suggestion that
12 the inmates in our correctional institutions in the
13 north, and perhaps elsewhere, are experiencing the
14 same kind of thing. We're seeing mass depression in
15 the form of behaviour disorders, adult delinquency.

16 Q Well, when you say,

17 "It perhaps simply goes unrecognized as
18 depression,"

19 do you mean all that is observed is in fact
20 depression, and these other things go unrecognized?

21 A Oh, sorry, no. That
22 other set of things is depression.

23 Q All right. So it simply
24 goes unrecognized as depression, it isn't recognized as
25 anything.

26 A That's right. It might
27 in fact be taken simply from the point of view of
28 value judgment on that kind of behaviour without
29 recognizing its origins.

30 Q Yes, O.K., I understand

Atcheson, Kehoe
Re-Examination

1 that.

2
3 RE-EXAMINATION BY MR. BAYLY:

4 Q Mr. Commissioner, I think
5 I do, but perhaps Mr. Kehoe could tell us, am I right
6 in understanding that depression is a term of art,
7 as well as a descriptive term?

8 A I'm sorry, a term of?

9 Q It's a term of art, it's
10 a special word, you use it in a special meaning as a
11 psychologist .

12 A Yes, that's right, I'm
13 sorry. Depression doesn't just indicate an unhappiness,
14 you might be very unhappy and still not be depressed.

15 THE COMMISSIONER: In clinical
16 depression you're mentally ill.

17 A Yes, right.

18 Q O.K., now you've got to
19 tell us what depression is.

20 A Depression is a set of
21 symptoms. Now probably Dr. Atcheson should be responding
22 to this rather than me, and please correct me if I'm
23 wrong, Dr. Atcheson, but it's the set of symptoms, a
24 syndrome, if you want, of such things as the feeling
25 of hopelessness, a lack of energy, often feelings of
26 self-doubt and a sense of guilt, with no real reason
27 for the sense of guilt, difficulty in concentrating,
28 perhaps anxiety, and on top of all that there is often
29 this feeling of sadness.

30 Q And all of those things

Atcheson, Kehoe
Re-Examination

1 listed at the top of page 12, from passivity to help-
2 lessness, are symptoms of the disorder that you've
3 described as depression.

4 A That's right. They don't
5 necessarily all have to be here in this individual to
6 constitute a diagnosis. May I turn to Dr. Atcheson and
7 ask you if you would agree with my description?

8 WITNESS ATCHESON: Well, I agree
9 basically, yes. The concept that I think Dr. Kehoe is
10 describing is that of a reactive depression. That
11 depression that one -- those symptoms that the human
12 being demonstrates when placed in a position that they
13 cannot cope with, they feel inadequate to cope with it,
14 and begin to show these signs of withdrawal, etc. There
15 are many other types of depression. The chemistry of the
16 brain is very much involved in some of them. They can
17 be treated quite effectively, but when you have a
18 reactive depression in which the circumstances to which
19 you're reacting are in fact valid, they're not delusional,
20 and they persist, then that depression tends to end up
21 in frustration and have no way of dealing with it, and
22 the equation of anger is the one that frequently
23 demonstrates itself.

24 Q Well, a pill wouldn't be
25 any good for it.

26 A Not in dealing with this
27 type of depression, no.

28 Q Well, this
29 is a pipeline Inquiry and you're saying that -- you're
30 not really offering a judgment on whether this pipeline

Atcheson, Kehoe
Re-Examination

1 and all that it will entail should come, you're really
2 saying, as I understand you both, that if it comes and
3 it brings a diminution generally in the self-esteem in
4 which native people regard themselves, it will result
5 in acceleration of the tendencies to behavioural
6 disorders that you've already observed. That's
7 essentially what you're talking about, isn't it?

8 WITNESS KEHOE: Yes, I would
9 agree with that.

10 Q And you'll leave it to
11 us to make that judgment. O.K., well, thank you very much,
12 Dr. ATcheson and Mr. Kehoe, and please convey our thanks
13 to Dr. Abbott, if you see him or are talking to him;
14 and would you, Mr. Bayly, convey our thanks to Dr. Abbott
15 and let me say it's been a most interesting day and
16 certainly I appreciate both of you taking the time and
17 trouble to come and to provide us with your views. So
18 thank you again.

19 A Thank you.

20 (WITNESSES ASIDE)

21 THE COMMISSIONER: I think
22 that that's just about enough for today, Mr. Scott. We
23 could start at 9 A.M., couldn't we?

24 MR. SCOTT: Well, we were
25 intending to start at 9 A.M., Mr. Commissioner. I think
26 we will have to sit one night this week'to finish these.

27 THE COMMISSIONER: Maybe we
28 could sit tomorrow night from 6 to about 9.

29 MR. SCOTT: A hockey game begins
30 then.

1 MR. BAYLY: Mr. Commissioner,
2 my witnesses are all here to begin tomorrow morning,
3 and in view of the lateness of the afternoon I would
4 agree we should not start them until tomorrow. There's
5 quite a lengthy presentation of five pieces of evidence
6 in the next panel which we could probably comfortably
7 get through in chief in the morning, and perhaps by
8 coffee or so in the afternoon, then we could finish
9 cross-examination.

10 THE COMMISSIONER: O.K., well
11 I apologize for not wanting to go any further but I've
12 got a bad cold and I think that if I'm going to do
13 justice to this material that's been presented today
14 I'd like to review it for an hour or two this evening
15 and if my mind's cluttered up by the views of the next
16 panel, that won't be helpful. If my cold is still bad
17 tomorrow, I can throw myself on the mercy of the panel.
18 I understand ~~they're~~ physicians. No doubt they can do
19 something about it swiftly.

20 MR. SCOTT: If they're like the
21 physicians I know, they haven't yet solved the problem
22 of the common cold and you'll just have to live with it,
23 Mr. Commissioner.

24 MR. BAYLY: They have a good
25 bedside manner though, sir.

26 MR. SCOTT: I wonder if I could
27 see the counsel for the participants before they leave?

28 (QUALIFICATIONS & EVIDENCE OF DR. ATCHESON MARKED
29 EXHIBIT 761)

30 (PROCEEDINGS ADJOURNED TO SEPTEMBER 15, 1976)

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Vol. 184

AUTHOR

Mackenzie Valley pipeline inquiry:

September 14, 1976 Yellowknife

DATE

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Vol. 184



MACKENZIE VALLEY PIPELINE INQUIRY

IN THE MATTER OF APPLICATIONS BY EACH OF

(a) CANADIAN ARCTIC GAS PIPELINE LIMITED FOR A
RIGHT-OF-WAY THAT MIGHT BE GRANTED ACROSS
CROWN LANDS WITHIN THE YUKON TERRITORY AND
THE NORTHWEST TERRITORIES, and

(b) FOOTHILLS PIPE LINES LTD. FOR A RIGHT-OF-WAY
THAT MIGHT BE GRANTED ACROSS CROWN LANDS
WITHIN THE NORTHWEST TERRITORIES

FOR THE PURPOSE OF A PROPOSED MACKENZIE VALLEY PIPELINE

and

IN THE MATTER OF THE SOCIAL, ENVIRONMENTAL AND
ECONOMIC IMPACT REGIONALLY OF THE CONSTRUCTION,
OPERATION AND SUBSEQUENT ABANDONMENT OF THE ABOVE
PROPOSED PIPELINE

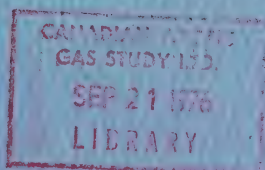
(Before the Honourable Mr. Justice Berger, Commissioner)

Yellowknife, N.W.T.

September 15, 1976.

PROCEEDINGS AT INQUIRY

Volume 185



APPEARANCES:

Mr. Ian G. Scott, Q.C.,
Mr. Stephen T. Goudge,
Mr. Alick Ryder, and
Mr. Ian Roland, for Mackenzie Valley Pipeline
Inquiry;

Mr. Pierre Genest, Q.C.,
Mr. Jack Marshall,
Mr. Darryl Carter, and
Mr. J.T. Steeves, for Canadian Arctic Gas Pipe-
line Limited;

Mr. Reginald Gibbs, Q.C.,
Mr. Alan Hollingworth, and
Mr. John W. Lutes, for Foothills Pipe Lines Ltd.;

Mr. Russell Anthony,
Prof. Alastair Lucas and
Mr. Garth Evans, for Canadian Arctic Resources
Committee;

Mr. Glen W. Bell and
Mr. Gerry Sutton, for Northwest Territories
Indian Brotherhood, and
Metis Association of the
Northwest Territories;

Mr. John Bayly and
Miss Lesley Lane, for Inuit Tapirisat of Canada,
and The Committee for
Original Peoples Entitle-
ment;

Mr. Ron Veale and
Mr. Allen Lueck, for The Council for the Yukon
Indians;

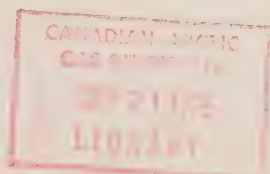
Mr. Carson Templeton, for Environment Protection
Board;

Mr. David H. Searle, Q.C.
for Northwest Territories
Chamber of Commerce;

Mr. Murray Sigler and for The Association of Municipi-
Mr. David Reesor, palities;

Mr. John Ballem, Q.C., for Producer Companies (Imperial,
Shell & Gulf);

Mrs. Joanne MacQuarrie, for Mental Health Association
of the Northwest Territor-
ies.



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Hildes, Mayhall, Schaefer,
Cass, Noble
In Chief
Yellowknife, N.W.T.

September 15, 1976.

(PROCEEDINGS RESUMED PURSUANT TO ADJOURNMENT)

MR. BAYLY: Mr. Commissioner,
we're presenting today a panel of witnesses on the
subject of health care and health care delivery, and
the panel consists of , starting from your right, sir,
Dr. Schaefer, Dr. Mayhall, Dr. Hildes, Dr. Cass, and
Gaile Noble. Now, all witnesses have been sworn
either today or previously.

DR. J.A. HILDES,

DR. JOHN T. MAYHALL,

DR. OTTO SCHAEFER,

DR. E. ELIZABETH CASS,sworn:

GAILE NOBLE, resumed:

DIRECT EXAMINATION BY MR. BAYLY:

Q If I could start with
you, Dr. Schaefer, I will go through each of the
witnesses' qualifications prior to your beginning your
evidence. Could we start with the curriculum vitae,
which is attached to the front of your paper? I under-
stand that you prepared at my request a history of
your qualifications.

WITNESS SCHAEFER: Yes.

Q And could you, for
the Commission, please go over your qualifications as
they are outlined in this curriculum vitae?

A Yes sir.

Q Now I understand that you

Hildes, Mayhall, Schaefer,
Cass, Noble
In Chief

1
2 were born in Betzdorf/Sieg, West Germany, in 1919 and
3 that you graduated from medicine from the University of
4 Heidelberg in the fall of 1944.

5 A That is correct, sir.

6 Q And that you took your
7 dissertation in Heidelberg in January, 1945.

8 A That's correct.

9 Q And that you did post-
10 graduate studies in internal medicine between 1945 and
11 1951 in Heidelberg, Baden-Baden and Freiburg.

12 A Correct.

13 Q And that you immigrated to
14 Canada in 1951 and that following your arrival you passed
15 the basic science examinations in Saskatoon in October
16 1, 1951.

17 A Correct.

18 Q And you then started your
19 internship at the Royal Alexandra Hospital in Edmonton
20 and you qualified for L.M.C.C. examinations in the summer
21 of 1952.

22 A Correct.

23 Q And that you entered
24 medical services at the Charles Camsell Indian Hospital
25 in Edmonton on November 1, 1952, and you subsequently
26 transferred to Aklavik in January, 1953.'

27 A Correct.

28 Q That you subsequently ser-
29 ved three years as a medical officer in the north, being
30 stationed two years each in the Western Arctic, Eastern

Hildes, Mayhall, Schaefer,
Cass, Noble
In Chief

Arctic and Yukon Territory.

A Correct.

Q That you further did
post-graduate work at the Charles Camsell and University
Hospitals in Edmonton which enabled you to acquire a
Canadian certification as a specialist in internal
medicine in 1963.

A Yes.

Q That you were placed in
1964 in charge of the Northern Medical Research Unit
based at Charles Camsell Hospital in Edmonton.

A Correct.

Q And that you became a
Fellow of the American College of Physicians in 1965,
and of the Canadian College in 1972.

A Correct.

Q You were also appointed
honorary associate professor of medicine at the Univer-
sity of Alberta on July 1, 1975.

A Correct.

Q And that you have attached
at my request a list of publications to reflect your
research work in various fields, ranging from physiology
to pharmacology and metabolism, these being predominantly
influenced by the changing epidemiological picture and
health needs of northern Indians and Eskimos over the
past 20 years in particular in Northern Canada.

A Correct, sir.

Q And that although it's not

Hildes, Mayhall, Schaefer,
Cass, Noble
In Chief

1
2 a medical qualification, that you were nominated in
3 January of last year for the Order of Canada.

4 A Correct.

5 Q Could I turn then to
6 you, Dr. Mayhall? You also have prepared at my request
7 a curriculum vitae which is attached at the end of
8 your evidence, and as it's in narrative form, I would
9 propose, if you're willing, to have you read that into
10 the record.

11 WITNESS MAYHALL: Fine.

12 I am an assistant professor in
13 the Faculty of Dentistry of the University of Toronto,
14 as well as a research associate in the Anthropology
15 Department of the Faculty of Arts & Sciences there.
16 I have been at the University of Toronto since January
17 of 1971. I have a B.A. degree from DePauw University,
18 Greencastle, Indiana; a D.D.S. degree from Indiana Uni-
19 versity; an M.A. degree in anthropology from the Univer-
20 sity of Chicago, and at the time this was prepared I
21 was completing my Ph.D. thesis and have since been
22 awarded a Ph.D. degree from the University of Chicago,
23 again in anthropology.

24 Since 1966 I have specialized
25 in dental anthropology working in Alaska with Aleuts,
26 Indians and Inuit; in Arizona with Pima Indians; the
27 Northwest Territories with Inuit; and most recently in
28 Northwestern Ontario with Cree and Ojibway Indians.
29 My principal areas of interest are dental morphology,
30 craniofacial growth and development, and the effects of

Hildes, Mayhall, Schaefer,
Cass, Noble
In Chief'

1
2 culture change on oral pathology.

3 Before re-entering university
4 in 1966 I was a dental officer for three years with the
5 Division of Indian Health, United States Public Health
6 Service, and served in widely diverse areas of Alaska,
7 treating Aleuts, Indians and Inuit.

8 I have published approximately
9 20 scientific papers relating to my area of specializa-
10 tion and have participated in numerous symposia as an
11 invited speaker. I am a member of several organizations,
12 including the International Association for Dental
13 Research, the Canadian Association for Physical Anthro-
14 pologists, the American Association of Physical Anthro-
15 pologists, the Society for the Study of Human Biology,
16 and the French Society of Dental Facial Genetics and
17 Anthropology.

Hildes, Mayhall, Schaefer
Cass, Noble
In Chief

1 MR. BAYLY: The qualifications
2 of Miss Noble have been read in previous to testimony
3 already given. I wonder if we could then turn to you,
4 Dr. Hildes.

5 At the back of your evidence
6 is attached a document prepared at my request which you
7 have entitled Personal Credentials, and if I could go
8 through those with you please.

9 I understand that you graduated
10 in medicine from the University of Toronto in 1940.

11 WITNESS HILDES: Yes, sir.

12 Q And that from that time
13 until 1954 your practice was largely in Southern
14 Canada. You'd had no contact with the Arctic.

15 A And others.

16 Q From 1954 though to about
17 1952 you were Associate Professor at the Department
18 of Physiology at the University of Manitoba and
19 consultant in Cold Physiology and Arctic medicine to
20 the Defense Research Board of Canada.

21 A Yes, sir.

22 Q From 1963 to approximately
23 1971 you were Chairman of the Northern Studies Committee
24 of the University of Manitoba?

25 A Yes, sir.

26 Q And from 1964 to the
27 present you have been Professor with the Department
28 of Medicine at the University of Manitoba and up to
29 1970, Director of the Clinical Investigation Unit at
30 the Winnipeg General Hospital?

Hildes, Mayhall, Schaefer
Cass, Noble
In Chief

1 A Correct.

2 Q From 1968 to 1973 you
3 served as Associate Director of the Health and
4 Epidemiology, Canadian International Biological Program,
5 Study on Eskimos.

6 A Yes, sir.

7 Q And that from 1970 to the
8 present, you have been Director of the Northern Medical
9 Unit and Medical Advisor to the Churchill Health
10 Center?

11 A Yes, sir.

12 Q And from 1973 to 1974,
13 you were on the Organizing Committee and Scientific
14 Program at the Third International Conference on
15 Circumpolar Health which was held in Yellowknife?

16 A Yes, sir.

17 Q And in 1973 you were a
18 health consultant to the Royal Commission on Labrador.

19 A Correct.

20 Q And I understand that
21 approximately half of your scientific publications
22 relate in one way or another to the Arctic and include
23 about fifteen published papers on human cold physiology,
24 about 8 on epidemiology of Arctic viral infections and
25 about 20 on specific clinical conditions in the North
26 and general reviews of health.

27 A That's right, sir.

28 Q And that your experience
29 geographically is greatest in the central Arctic but
30 that you have worked in the Eastern Arctic, in the

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1
2 Northern Yukon and have made briefer visits to other
3 parts of the Canadian Arctic, Labrador, Alaska and
4 Scandinavia.

5 A That's right.

6 Q I take it those were in
7 connection with your work?

8 A Yes, sir.

9 Q Yes. For the past six
10 years you have been Director of the Northern Medical--
11 as Director of the Northern Medical Unit you've been
12 responsible for the provision of medical services at
13 the Churchill Health Center which includes the Churchill
14 Band of Northern Indians and through agreements with
15 Health and Welfare Canada for the provision of a variety
16 of visiting physician services to the settlements in
17 the Keewatin District.

18 A Correct.

19 Q And in addition to
20 physical services this has meant a central involvement
21 in the planning and operation of the Churchill Health
22 Centre.

23 A Yes, sir. I think, Mr.
24 Bayly, the comments on the second page that I originally
25 submitted have actually been included in my brief and
26 perhaps we can save time by just leaving it out at this
27 point.

28 Q All right. Well, then
29 we'll just file this with your evidence, Dr. Hildes, if
30 the Commission is agreeable and they'll form part of the

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1
2 record. You have included, at my request, the biblio-
3 graphy to which you referred, of papers which you either
4 authored or co-authored.

5 A Yes.

6 Q Dr. Cass, if I
7 could turn to you please.

8 You have prepared at my
9 request a personal history which was attached to your
10 evidence.

11 WITNESS CASS: Yes, I did.

12 Q I understand that, if I
13 may go over your qualifications with you, that you
14 graduated in 1927 and received an M. R. C. S. and an
15 L. R. C. P. degree at the Ophthalmic House as a surgeon
16 at St. Mary's Hospital in London, England. Is that
17 correct?

18 A Yes.

19 Q And that in 1928 you
20 received an M. B. and a B. S. in London and became at
21 that time an Out-patient House Surgeon.

22 A Yes.

23 Q And that in 1929 you were
24 a Gynecology and Obstetric House Surgeon at St. Mary's
25 Hospital, London, London and you were a junior and
26 senior resident during that period?

27 A Yes.

28 Q And that from 1930 to
29 January, 1931 you were an anesthetist at St. Mary's
30 Hospital and with a resident junior and later senior

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1 anesthetist.

2 A Yes.

3 Q And in 1931 you were the
4 senior clinical assistant, Ophthalmic Department, St.
5 Mary's Hospital. You were the out-patient officer,
6 Moorfields' ^{Ophthalmic} Hospital, London, England. Officer in charge
7 of children's Ophthalmic clinics, St. Mary's Hospital.
8 Officer in charge, Orthoptic clinic, St. Mary's Hospital.

9 A Yes.

10

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1
2 Q And in 1933 you were the
3 junior ophthalmic surgeon of New Sussex Hospital in
4 Paddington.

5 A Yes.

6 Q And in 1935 the chief
7 clinical assistant, Moorfields Eye Hospital; chief
8 clinical assistant, Ophthalmic Department, St. Mary's
9 Hospital, Paddington.

10 A Yes.

11 Q In 1935 Senior ophthalmic
12 surgeon, New Sussex Hospital, in Brighton.

13 A yes.

14 Q In 1939 you were awarded
15 a research scholarship of London University for research,
16 etiology and treatment of strabismus.

17 A Yes.

18 Q And that you were invited
19 by Governments of Argentina and Brazil to give a course
20 of seven lectures in these countries on these subjects
21 as a result of eight years of research work done at
22 St. Mary's Hospital in Paddington.

23 A Yes.

24 Q And that in 1940 you were
25 appointed senior opthamologist to the Forces and were
26 the first woman opthamologist in the R.A.M.C. and the
27 only one admitted with the rank of major as a senior
28 opthamologist.

29 A Yes.

30 Q And that in 1943 you were

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1
2 transferred overseas to Gibraltar after attending the
3 plastic unit in East Grinstead for three months.

4 A Yes.

5 Q In 1945 you spoke to the
6 Spanish at an ophthalmic meeting in Madrid on strabismus.

7 A Yes.

8 Q In 1946 you gave a course
9 of lectures in Spanish on the subjects referred to
10 above, and were appointed as ophthalmic surgeon to the
11 Military & Colonial Hospitals in Gibraltar, which
12 post you held until 1955.

13 A Yes.

14 Q Going then to 1955, you
15 were appointed as an expert on trachoma to do a survey
16 by the World Health Organization in the Middle East;
17 due to the disturbances in the area that survey was
18 not carried out.

19 A Yes.

20 Q In 1956 you immigrated to
21 Canada and you were appointed as ophthalmologist to the
22 Department of National Health & Welfare.

23 A Yes.

24 Q In 1958 you were trans-
25 ferred to the Northwest Territories in April of that
26 year.

27 A Yes.

28 Q And I understand you have
29 been working in the Northwest Territories since that
30 time.

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1
2 time.

3 A Yes.

4 Q During that time, though,
5 you did do the following things. You took a course
6 in plastic surgery in New York in 1963.

7 A Yes.

8 Q And in 1964 you spoke at
9 the Pan-American Congress of Opthamology in Montreal
10 on tubercular ocular conditions in the north.

11 A Yes.

12 Q In 1966 you gave a lecture
13 at the International Congress of Ophthalmology in
14 Munich on "Ophthalmology in the Northwest Territories."

15 A Yes.

16 Q And in 1967 you were
17 invited to give a lecture to the C.A.M.S.I. I wonder if
18 you could tell us what that is?

19 A Well, that was the
20 Canadian Association of Medical, I think it was Students,
21 Medical Students. They had this group in the university
22 and they came up to Inuvik and they asked me if I'd go
23 and lecture to them, and after that they asked me if I'd
24 teach them about Indian customs so they would not upset
25 anyone when they went into outlying stations.

26 Q All right, and you also
27 gave at that time lectures on the effects of civiliza-
28 tion on the Eskimos and you were invited to the Inter-
29 national Myopia Research Institute at the Mount Sinai
30 Hospital in New York --

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1 A And Mount Sinai Hospital.

2 International, yes.

3 Q All right, and to the
4 Manhattan Ophthalmogical Society, the Royal Canadian
5 Institute in Toronto, and at Kingston University in
6 Kingston, Ontario.

7 A Yes.

8 Q To deliver --

9 A Lectures.

10 Q -- lectures on ophthalm-
11 ology in the Arctic. In 1970 you organized the first
12 Congress of Geographical Ophthalmology in Yellowknife,
13 Northwest Territories, in which 13 different countries
14 were represented, mostly by ophthalmologists.

15 A Yes.

16 Q And at that time a per-
17 manent organization was formed and you were elected
18 president of that organization.

19 A Yes.

20 Q And that you were invited
21 at that time as a panelist on Communications Congress
22 in Yellowknife in September, and at the Man in the North
23 Congress in Inuvik in December of that year.

24 A Yes.

25 Q In 1971 you were invited
26 to lecture at the Circumpolar Conference of Medicine in
27 Finland, by the Finnish Ophthalmologists.

28 A Yes.

29 Q And that you organized
30 as president, the Second Congress on Geographical

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1
2 Ophthalmology in Jerusalem, which again was a world
3 representation by approximately 300 ophthalmologists.

4 A Yes.

5 Q You were also invited
6 as a guest by the Argentinians to lecture at a Congress
7 on Strabismus in November of that year.

8 A Yes sir.

9 Q You were also invited
10 twice to Los Vegas but were unable to go. Does that
11 have anything to do with medicine?

12 A Well, there was a strike
13 on, you see.

14 Q And that in that year you
15 attended a course on ultra-sonics in Paris.

16 A Yes.

17 Q In 1972 you lectured
18 at a symposium on Arctic Medicine, the Canadian Society
19 of Ophthalmology.

20 A Yes.

21 Q And in 1973 you assisted in
22 the organization of the Third Congress of Geographical
23 Ophthalmology in Cadiz, Spain, and at that time pre-
24 sented two papers on the north.

25 A Yes, I did.

26 Q In 1974 you attended
27 the International Society of Ophthalmology in Paris.

28 A Yes.

29 Q And the Fourth Circumpolar
30 Congress --

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1

2

A Yes, I did.

3

Q -- where you gave a paper

4

on strabismus amongst Indians and Eskimos in the,

5

Northwest Territories.

6

A Yes.

7

Q In 1975 you organized

8

the Fourth Congress of the International Society of

9

Geographical Ophthalmology in Edinburgh, Scotland,

10

A Yes sir.

11

Q And in 1976 you presented

12

a paper on ocular tuberculosis in Vancouver.

13

A Yes sir.

14

Q And you're presently

15

practicing in Fort Smith.

16

A Yes sir.

17

Q Could we then go to your

18

evidence, Dr. Schaefer, and I'd ask you to present

19

that, if you will, to the Commission?

20

WITNESS SCHAEFER: Mr.

21

Commissioner, I have been asked to testify to the

22

value of traditional forms of nutrition of Northern

23

Indians and Inuit and to discuss the effect of loss

24

of their traditional food resources or nutritional habits

25

on their health picture as observed consequent to various

26

forms of development in the north.

27

I shall do so by:

28

(1) exhibiting evidence of the superior nutritive value

29

of traditional native food resources such as game (from

30

land or sea), meat and fish compared to those found in

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1
2 expensive imported meats, and the higher vitamin content
3 of formerly more extensively used native plants and
4 berries compared to imported garden produce.

5 (2) Then I should do so by depicting the trends of
6 changing nutrient consumption and nutritional habits
7 observed in northern native population groups with
8 development and urbanization.

9 (3) Then I should do so by demonstrating the direct
10 consequences of these changes to their health as ob-
11 served over the last 20 years in various areas and age
12 groups.

13 In the second part of my
14 presentation, I shall discuss other new dangers to
15 health and life of northern native people which by
16 now are actually recognized by government authorities
17 as well as the people themselves as their most important
18 and almost overwhelming problems; namely social upheaval
19 and degradation and alcoholism, which even if at first
20 glance not appearing directly related to nutritional
21 change, are nevertheless all tied in and consequent to
22 the uprooting of their lifestyle and social structure
23 and loss of personal identity within that structure,
24 which evolved and was shaped above all to fulfill
25 nutritional needs and to allow survival in an extremely
26 harsh and poor environment.

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1
2 Then I propose to look at some
3 examples from the past and there are numerous examples
4 from the times of the whalers and furtraders to more recent
5 events such as the construction of the Alaskan and
6 Mackenzie Highway, DEW line build-up, CAN-tungsten,
7 Alaskan Oil Pipeline construction, et cetera.

8 All these events certainly had
9 very marked impact on the health and life of northern
10 native people, but there were also quite interesting
11 differences in the health consequences and it may be
12 worthwhile looking at the possible reasons for these
13 differences as a possible guidance for action in the
14 future.

15 Perhaps we should also discuss
16 in this context experiences from the past in regard
17 to the impact of greater cash earnings and material
18 affluence due to greater employment opportunities and
19 higher wages during construction booms on the health
20 picture of northern natives as a generally unquestioned
21 assumption that greater earnings and material wealth
22 would improve social and physical health, has influenced
23 in the past, government planning and policies at all
24 levels in favor of industrial development and native
25 employment; even short lived construction jobs
26 at any price and is now used as an argument by many
27 developers.

28 Finally, in my presentation,
29 I should address myself to the impact on health care
30 delivery facilities and personnel to be expected with

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1 sudden large scale development in the Canadian North.
2 Here a glance across the border to Alaska is in order
3 with due consideration, however, of the roughly seven
4 fold larger population base and facility bases in
5 Alaska versus the Northwest Territories which naturally
6 should provide because ^{of} it's a larger base, much more
7 resilience for any sudden new demands put on various
8 services here.

9 If I may then perhaps proceed
10 to the factual presentation, I must ask for your
11 indulgence ^{that} I dim the lights a bit because I have
12 a few slides to show. Please sir, you would be so kind
13 to help me. This slide, this table may look familiar
14 to you. You have seen it in a similar form but not
15 quite exactly the same form in Mr. Peter Usher's
16 presentation.

17 I take the liberty to show it
18 again because Mr. Usher was very much asked and pressed
19 in the cross-examination about the sources of his
20 table. What I want to emphasize is the difference I
21 do show in this table. I do show in this table the
22 protein and fat content of prominent native food compared
23 with imported meat resources. What Mr. Peter Usher
24 particularly zeroed in on was the higher protein content
25 of the native food. If you compare moose, caribou and
26 seal between 26 and 32 percent protein with those of
27 pork and chicken and veal and beef ^{somewhere} between 16 to 20,
28 even 20 percent, it's quite clear that the protein
29 content is much higher.

30 Mr. Usher's table differed

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1
2 slightly from mine. He inserted indeed because he
3 is a good and cautious scientist presenting evidence
4 from a field which was not his own field he took the
5 lowest values. In his table the values for moose and
6 caribou were one or two percent always lower than
7 mine.

8
9 There have been different
10 analyses done and as I say, he wanted to rather under-
11 state than over-state his case. I do, however, feel
12 no compulsion whatsoever to show this table from the
13 Alaskan study as this was done perhaps by the foremost
14 nutritionist authorities in the world at that time
15 which involved several American universities active
16 in the field of nutrition, together with the I.C.N.N.D.
17 a body which was formed to advise the Defense Force
18 of the United States and also NATO countries on
19 nutritional requirements of the people as well as
20 teaching nutritional research and HELP Program in
21 Latin American and other developing countries.

22 I think the authorities who
23 did this are unquestioned and therefore I present
24 this table in this form. What Mr. Peter Usher
25 did not zero in on was the fat content and I think,
26 as a medical man, I'm not only concerned with the plus
27 side, the protein content, but also with the minus
28 side and we do know now that the fat content of our
29 meat is a very important part of what we should look
30 at and it's generally accepted by the medical profession
, by now,
that the high fat content of our domesticated meat is

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not a desirable feature and you will notice in this
table that in general the fat content of imported meats
is in the order of ten fold higher than that of the
meat and fish obtained from the country ^{here} in the North.

We may go on to the next
slide please.

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Thus a comparison of wild
vegetables and foods obtained by, for example, the Cree Indians
had similar values that you would obtain here compared
with some garden produce, and you may notice that
both Vitamin A as well as Vitamin C content of the
wild foods which are in the lower half of this table
is substantially higher than that obtained in the
garden produce. Just as a sideline, the
value of it is much under-rated now, and unfortunately
also under-used, native food resource in the vegetable
field.

If I may go onto the next
slide, please. It has been claimed even in testimony
given before this Inquiry that forget about it, all
the damage was done and nobody is living off the
country any more. This is not true. We did recently in
this Northwest Territories region a very detailed
infant^{morbidity and} mortality study and part of that was a dietary
questionnaire which parents of newborn babies in one
year, born between the 1st of April, 1973 and the
1st of April, 1974, and in that enquiry which was derived
in co-operation of our nurses with the parents of the
newborn babies, after home visits, the following claims,
and I must say claims were made that the Inuit, 21% of
those families who had babies born that year claimed to
live predominantly off -- 17%, predominantly off native
food; but 62% claimed to use at least half of their food
resource of native origin, and only 21% lived exclusively
from store food. With Indians it was slightly less to-
wards the native side, as you can see, but that contrasts

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very much so with the white population of the Territories.

The conclusion is that the natives do still use a very essential part of their food from native food resources.

If I may pass onto the next slide, please. I did some ten years ago a nutrition study of a pilot project in several settlements in the Canadian north trying to see what the trends are. You saw in the foregoing table the actual consumption right now or the actual claimed consumption right now; but there are great differences in different localities. You will find much less native food eaten in a district like Inuvik compared to let's say, Pelly Bay, and you can see already the trend in a study done ten years ago if you look for example at the second column "protein" and look at one of the, at that time, almost 90% of the families living really off the land were living in Pangnirtung and the district, and it was 318, that is two to three times higher protein consumption in that group than compared to the most urbanized group at that time surveyed, which was Frobisher Bay, with 128 grams.

If we may pass onto the next slide. There was a substantial carbohydrate consumption in all groups, as you may have seen in the foregoing slides, but we must differentiate between what types of carbohydrates they use in these so-called half traditional society. Since the whalers and traders time the natives have been introduced to certain staple

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1
2 foods such as flour and rolled oats, etc., but we must
3 differentiate between carbohydrates. Those which are rapidly
4 absorbable, mainly sugar in all forms, and those which
5 are less rapidly absorbed and do therefore not lead
6 to sudden peaks of blood sugar, and like cereals and
7 flour, and you will see a shift from predominantly
8 over 80%, almost 82% in the more slowly absorbed forms
9 ^{were} consumed in 1959 while eight years later in '67, this is
10 now one trading district, the Cumberland Sound trading district,
11 eight years later they have complex cereals had fallen to
12 near 50%, and their sugar in all forms had risen from
13 26 pounds per head per capita four fold figure of 104 pounds
14 -- in the meantime it has risen to 140 pounds, and from
15 18% to at that time '67 to 44%, to now well over 50%
16 of their carbohydrate consumption.

17 Now the next slide, please.

18 What that did to the teeth, and I shall not spend much
19 time here because we have much more of a knowledgeable
20 scientist here sitting to my right who will spend more
21 time on it, but what it did, even a superficial observer
22 could see on this graveyard of teeth, a 22-year-old man in
23 Frobisher Bay in 1965 and this is in contrast -- next
24 slide, please -- to what is really people from Minto
25 Inlet, 200 miles north of Holman Island, came once a
26 year to the trading post and didn't have enough space
27 on their sled to take too much sugar home, and this
28 elderly man in receipt of an old-age pension at that
29 time with his original set of teeth, chewed down, like
30 his wife, down to the gums because of the chewing of

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1 boots, etc. and this man, by the way, to the left,
2 the youngest one also has, I think 24 or 25 years old,
3 compare that with the foregoing picture.

4
5 Next slide, please. This
6 as I said, I want to leave to Dr. Mayhall, who has done
7 very extensive research in Alaska as well as in the
8 Canadian Arctic, and in this particular attention is paid
9 to the dietary factor in that we will hear more about
10 it but turning to another field which is not so obvious
11 to the eye, to the blood, look at the difference in the
12 hemoglobin values, then you compare to population
13 figures at that time. This is in '64, the survey done
14 in '64, that was just before the big gathering in of the
15 hunting/^{camp}population of Northern Baffin into big
16 settlements, the blue columns, the dark blue as well as
17 the light blue columns are both from the Northern Baffin
18 zones, that is Grise Fiord and Arctic Bay, and you will
19 see in particular in the sensitive age and sex groups,
20 that are growing children and women of childbearing
21 age.
22 There are the essential differences compared to the
23 red columns, which is a group of Eskimos from south on
24 part of Ungava Bay of Arctic Quebec, who have
25 moved five years earlier before this survey into the settlement
26 and they are working on some industrial subjects or
27 whatever and at any rate their nutrition had changed and you
28 certainly see it.
29 Next slide, please. But this
30 was not just something peculiar to Arctic Quebec as
you can see when you compare the hemoglobin values in

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1
2 1964 in Northern Baffin, the blue columns, and the
3 red columns in 1968, done with exactly the same
4 technique, there is a very remarkable and significant
5 falling off of the hemoglobin in the again iron
6 deficiency sensitive age and sex groups which are
7 growing children and women of child-bearing age.

8 If we may turn to the next
9 one, please. We see the effects go a little bit
10 deeper than ^{seen} in dental health, in a relatively
11 easily done hemoglobin values. If we look at the
12 metabolic picture, you may remember my second slide
13 which I did show, depicting the carbohydrate, in
14 particular the sugar consumption in all forms, and
15 I look here now at the metabolic consequences of this
16 dietary change and I was particularly interested in
17 the at that time quite difficult diagnosis of diabetes
18 -- or not diabetes, quite a few of the Eskimos in south-
19 ern hospitals excreted sugar, so doing systematic
20 tests of our normal standard glucose tests more
21 than 50% would show something that we in our population
22 regard as a diabetic type of glucose tolerance. However,
23 I didn't believe they were diabetic. If we turn to the
24 next one I will show slide 2 of that.

25
26
27
28
29
30

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1 A glucose tolerance in the
2 fasting state as we normally do in hospitals, many
3 of them, those 50 percent ^{show an} abnormal curve, the
4 blue one on top. ^{If} it repeats the same test one hour
5 after meat meal the test is quite different. The
6 red curve much lower and the insulin output is much
7 earlier. Next slide please. This was done on the
8 great series of patients, not just on several, and you
9 see then the means and standard deviation on it, a norma-
10 lization of the glucose tolerance curve, a normalization
11 of the insulin output. I don't want to
12 bother you much more with that. If you may turn to
13 the next one please.

13 There are some metabolic
14 consequences naturally of a disordered carbohydrate,
15 in particular, sugar metabolism. We do know that
16 diabetics have a much higher incidence of arterial
17 calcification in legs and elsewhere in the body. Now,
18 for that reason and other reasons, I did a survey
19 of calcifications, visible calcifications by X-ray .
20 In the aorta in our chest X-rays, which we routinely did
21 at that time once or twice yearly and in leg X-rays
22 which in addition I undertook and summarized that and
23 you will see very marked differences between certain
24 areas of the Arctic, between the south-east Arctic there
25 were 19 percent of those between 50 and 59 did
26 show calcification while much less though or here's
27 a summary down below ^{total} 40 to 69 ^{which} are the best years
28 to test that, it was only 3.6 percent which is highly
29 significant with the numbers done.

30 Next slide please. If you

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1
2 look at some special groups, those who had more than
3 ten years employment at the DEW line and eating three
4 huge big meals a day and all being employed in Rankin
5 Inlet by the mining companies, 50 percent of those
6 men did show those calcifications. While in the hunting
7 camp population and I want to emphasize, we used the
8 same ^{age} group. Always the same decade was used. It was
9 two percent and so on. So, they are very highly
10 significant. Underneath are the statistical significance
11 stated for this.

12 Next one please. If you
13 compare that with the dental health, there seem to be
14 a congruence, a true regression line between villages
15 who had a high incidence of dental care, also had the
16 high incidence of arterial calcification; which I don't
17 say rotten teeth make arteries close. This would be
18 nonsense but what I want to point is the dietary change
19 seems to affect both.

20 Next slide please. Maybe I
21 should look at my text in between. I think we can
22 carry on. Yes, if we do speak about nutrition, so far
23 I have given you tables about food consumption, the
24 value in regard to protein, in regard to vitamin; the
25 area of nutrition. The time in life where nutrition
26 has ^{perhaps} / a most important impact is really in infancy
27 and we seem to overlook that often. As you know, all
28 the original methods of infant nutrition in all people,
29 not just within Indians, but in our own society too,
30 until two or three generations ago was breast feeding

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1
2 and in the case of our original people, prolonged breast
3 feeding and look at this young eighteen year old mother
4 with her first child, completely absorbed in her task,
5 because she knows about the hazards of the harsh
6 environment to that child, so she really pays attention
7 to it and disregards that silly photographer with the
8 flash light.

9 Next one please. Look at this
10 now, what the Eskimo artist himself perceives about
11 the change of time. There are two children where there
12 used to be only one. The normal births in spacing
13 was three to four years apart and now suddenly we are
14 faced with a tremendous population explosion
15 and why the milk bottle is used.

16 Next one please. But we are
17 not so much concerned, although I think my colleague,
18 Dr. Hildes and --, apologize to you, did a very good
19 study together with some anthropologists and did show
20 this relationship between prolonged lactation and
21 child spacing and you can clearly see that there is a
22 beautiful correlation in both age groups, young and
23 old women between the lengths of lactation and the
24 infant mort.

25 But I should, as a Doctor,
26 concern myself more with disease. So, please turn on
27 to the next. Don't want to take time here. The
28 infant nutrition pattern right now is markedly changed.
29 I said it was typical to breast-feed a child and care
30 for it for three years methods outmoded, but now

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1
2 that isn't any more the case and it shows you again from
3 the study which I quoted before; although the Inuit
4 are still to a larger degree than the two other
5 population sectors practicing breast feeding, it has
6 tremendously fallen down even in them.

7 Fortunately I must say and
8 I'm very proud to say that we have been able in medical
9 service, for example, to increase the rate of breast
10 feeding in mothers delivering in the Inuit Hospital
11 in the last two years, three fold and in Frobisher
12 Bay, two fold. We are very proud of that achievement.

13 Next one please. So, we asked
14 them together with the populations themselves. The
15 native groups themselves are very concerned about it.
16 We are coming back to a more rational type of infant
17 nutrition. But I should maybe concern myself and
18 demonstrate to you what it does when you suddenly
19 disrupt dietary habits, in particular infant feeding
20 habits. This was a large scale study done by our
21 department in Indians. Indian children born across
22 the country, this includes natives of sophisticated
23 and let's say acculturated populations as the Six Nation
24 Reserve in Brantford, Ontario and is therefore a little
25 bit deluded because they have a much lower infant
26 mortality rate but in every month you can see significant
27 excess of infant mortality for the bottle fed children
28 compared to the breast fed children.

29 So, it does have a very
30 decisive effect on health and life of the babies. Next

Hildes, Mayhall, Schaefer,
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In Chief

1
2 one please. In our own, we always speak about the
3 dreadfully high infant mortality in the aboriginal
4 times. I think we are perhaps a bit superficial. We
5 look at the worst spot and start then our statistics
6 and graphs and show what we all did against it. We
7 should show as early as we have reliable data and this
8 does show that in 1951, this is in three year running
9 averages, so we get a better statistical basis, there
10 was a much lower infant mortality than in 1955 to '57
11 when it peaked and you know what happened in '55 to
12 '57. I'll come back to that later.

13 Next one please.
14
15
16
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Hildes, Mayhall, Schaefer,
Cass, Noble
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1 THE COMMISSIONER: Excuse me,
2 Dr. Schaefer, just before we leave that, you said that
3 we have a tendency to say that the provision of health
4 services over the last generation has sharply reduced
5 infant mortality from what it was. You say that that
6 may be a specious assumption to make. I didn't quite --
7 could you enlarge on that?

8 A Yes, I think I should
9 because I may be misunderstood. We have a tendency
10 to start with the worst point and show then our
11 improvement. I think there is no doubt that medical
12 science has cut infant mortality drastically from abor-
13 iginal times, but we are also wrong -- and this I wanted
14 to emphasize -- to take the point at worst infant
15 mortality. Right now, I just listened about five days
16 ago to a talk by Dr. Gibson, who is now practicing in
17 Edmonton but practiced before in various areas in
18 Africa, where he said infant mortality now in Nigeria
19 is near 50%. But it was never that high before. It is
20 now that high with the emergence of Kwashiokon
21 which is a new thing with the early weaning of children
22 and not high feeding then, or at least to such
23 degree as we see it now in certain developing countries,
24 the ^{protein} malnutrition in children ^{early weaned} we didn't see in aboriginal
25 times. This is what I wanted to point out.

26 But this must not deflect from
27 the very decisive lowering which was achieved by medical
28 services or the medical profession as a whole of infant
29 mortality in all societies, and including ^{the} native society.

30 Q Fine, thank you.

Hildes, Mayhall, Schaefer,
Cass, Noble
In Chief

1
2 A Infant mortality, just as
3 a clarification, as pointed out has drastically.
4 come down, particularly after the advent antibiotics.
5 What has less come down is infant morbidity, and one
6 of our big health problems in the Canadian north, and
7 we have good evidence now that this is ^arelatively new
8 problem, at least to such a degree, that is chronic ear
9 disease. Between 30 and 40% in some areas
10 even higher, of children showing signs of chronic ear
11 disease, or having had prolonged and recurrent episodes
12 of running swollen ears. Now this is certainly an event
13 which was not seen a generation ago, and I have a hint
14 that this might be related to the mode of infant nutrition
15 and so I give the explanation that there is a clear rela-
16 tion shown,
17 it was much, much higher in those which are weaned at
18 birth or within the first month than those who had an
19 average of breast feeding for six to nine months and it
20 was even lower in those for more than 12 months.

20 I think we can turn over to,
21 if I may turn over to the next slide and I will go very
22 fast through those. It is more than nutrition, although
23 nutrition is very important. The resistance to disease
24 perhaps transmitted not by nutrition but by immunological
25 factors which we know now are transmitted in mother's
26 milk, but there is something else which was a very, very
27 important thing, the
28 emotional factor in early infancy. As I showed in a picture
29 before, this mother is concerned with her child and
30 that child has a feeling of security, and fulfilment and
satisfaction which is not evident now when you see a child

Hildes, Mayhall, Schaefer,
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1
2 lying with a bottle propped up on a pillow in the
3 corner of the bed oozing all over and in dirty diapers.

4 Next picture, please. They
5 didn't have diapers, and nevertheless that mother
6 didn't get wet around her, or the child would
7 have died from exposure because insulation powers
8 would be lost. But this child at three months of age
9 or even shortly after birth never wets in the parka, the
10 mother knows when the child wants to move, so close
11 was the inter-action between mother and child.
12 And we know from our psychology, child psychology now,
13 has a tremendous impact later in life too in security
14 feelings.

15 Next one, please. What's the
16 role and interaction between mother and child really
17 was perceived in the traditional society, you see from
18 this carving again by an old woman in Repulse Bay.
19 That child which she has carried in the mother's parka
20 and looks over right shoulder or left shoulder but
21 not right in the middle of her shoulder, but here he
22 bunches up unconsciously, he puts the role up, that
23 child dominates the woman's life for the next three
24 years and she, figuratively speaking, adjusts her
25 entire personality to that child, to the fulfilment of
26 the needs of that child.

27 Next one, please. This woman
28 has no contact with the children any more. She is borne
29 down by the load of too many children.

30 Next one. The mother was

Hildes, Mayhall, Schaefer,
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1
2 loved and the absolute centre of the family.

3 I think I should perhaps not expend my time, but now she
4 has less than a role, she is idle.

5 If we go on, please. The
6 children, they are secure while now they have lost the
7 shelter
/and the intimate mother and child interaction now.
8 The nutritional and emotional and sensory deprivation is
9 now experienced in infancy, which was never there
10 before.

11 Now next one, please. The
12 father, his role perhaps has the more emphasized
13 by our mental health teams, so I may pass over this to
14 save time, and the education was continuous from infancy
15 on, by imitating his parents.

16 Now next one, please. How is
17 it that went on? I mean the child is doing what
18 the mother is preparing food and the child uses what
19 she does, but he is not made to feel useless, he does
20 the same thing and gives it to the mother and the mother
21 makes a little food out of it, so he learns playful
22 imitation to assume a useful role in society.

23 Next one, a little boy, he was
24 six years old or seven, I think, bringing his first caught
25 fish home. Well, that is very important.

26 Next year, two years later, he
27 will bring his first seal home, so he did progress
28 in a useful manner into a useful member of society and
29 didn't go through all the frustrations of our present-
30 day youth.

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Next one, please. The inter-
action of the family was very close, was complete and
unquestioned interdependence, and now they are drifting
apart. There is no essential relationship and essential
need any more.

Next one, please. That leads
to the value.

If I may now return to my
text. Important are the nutritional changes for the
health of northern natives are -- and I may put the light
on
the nutritional changes for the health of northern
natives are, and the extent of deficiencies in Inuit and
Indian populations when they are abandoning
traditional food resources and feeding habits, have well
been documented by Alaskan as well as Canadian research-
ers, and most recently by Nutrition Canada, indeed of
vital importance, as I could demonstrate with a great
increased mortality in bottle-fed Indian and Inuit infants
but the greatest and most dramatic danger to health and
life of northern native people has arisen in recent
years from other factors, namely social upheaval and
degradation and alcoholism.

Indeed, in sheer numbers of
people killed by homicide, suicide, other violence and
accidents, most of them alcohol-related, those reported
under this category have been leading all
other causes of death by a wide margin for the Yukon
Territory Indians for more than 15 years now, and the
Indians and the Inuit of the Northwest Territories now

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1
2 by almost ten years, and comprise in excess of 30%
3 of all deaths in ^{natives} of the Northwest Territories for
4 a number of years now, I believe six years now.

5 Another parameter of social
6 disturbance and health consequences is the venereal disease
7 picture. I must apologize, one graph but we don't
8 need to put the lights out for that is the last one, I
9 guess I show. That's the two last ones. Yes, you see
10 the gonorrhoea picture, I must apologize/^{not}for showing
11 the last years, this next one comes nearer to the
12 present date, but this is a semi-logarithmic scale
13 therefore you don't see the actual numbers, they are
14 toned down a bit but you see still a rising graph. But
15 too bad I didn't bring the last one along. In '74 it
16 levelled off and for the last eight months the gonorrhoea
17 rate for the first time in 15, almost 20 years, 18
18 years has come down but 30 to 40%, which we should
19 be grateful for because this is almost unhopd for,
20 but I think it testifies to, and sometime I would like
21 to place my services together with a new native cor-
22 poration in awareness of their own dangers.

23 I believe the stabilizing
24 Period is right now going on, but what would happen
25 if we go on suddenly now while we are having evidence
26 that we are reaching a stabilizing period with a
27 huge sudden upheaval and we know what happened to
28 the V.D. rate in Alaska, that went skyrocketing
29 there, and I think we had no hope to hope differently
30 for our area. So I think I'll return to my text.

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1 It would, however, be one
2 sided, unfair and unbalanced to enumerate only untoward
3 effects of changes in nutritional habits and ways of-
4 living on the physical, mental and social health of
5 northern native people brought about by greater contact
6 with the outside world and various development thrusts
7 coming from without rather than from within their
8 own world.

9 I should therefore not fail
10 to mention that almost regularly recurring episodes
11 of famine and starvation, which in aboriginal times
12 more than disease or any other factor curbed population
13 growth, became, with more effective lines of communi-
14 cation and transportation, an almost forgotten thing
15 of the past.

16 We must acknowledge that the
17 life of the northern hunter became less arduous and
18 his returns easier and richer with the advent of the
19 rifle, and his mobility greater with the larger dogteams,
20 thus possible, and even more so with motorboats and
21 motorsleds nowadays. Similarly life has become less
22 filled with unending, ^{tedious} work for women making and repairing
23 skin clothing, boots and tents, and life more com-
24 fortable for all in oil heated and electricity lighted
25 spacious houses versus crowded small igloos and tents
26 heated and lighted by nothing more than the flickering
27 seal or fish oil lamp.

28 Of more direct interest to us
29 in medical services were transportation facilities which
30 developed and brought and enabled us to bring medical

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1 help to formerly remote and isolated people and to
2 evacuate critically ill children and adults speedily
3 to hospitals, and thus, often saving their lives.
4 Emergency recreation facilities we must admit came
5 first to white parts of the central and eastern parts
6 of the Canadian Arctic with the string of the airports
7 built at the time of DEW-line construction. Thus, the
8 same DEW-line sites initiated more often than not the
9 cause of events which led to the need for emergency
10 evacuations is the other side of the coin one tends
11 to overlook.

12 I shall elaborate that later.
13 What, if any impact can we expect on the health picture
14 of and health care delivery of native people in the
15 Canadian North by the massive infusion of men and money
16 in a relatively short period of time expected to come
17 into parts of the Canadian North with the proposed
18 mammoth construction project?

19 All kinds of hypotheses are
20 possible if one argues in vague and questionable
21 generalities and disregards historical parallels which
22 are really pertinent to our question because of the
23 locality and people involved. I have heard and read some
24 fanciful examples of this, including testimony presented
25 in this Inquiry, based, for example, on the widespread,
26 even if faulty generalization, that greater cash income
27 would bring improved social conditions and with that
28 better nutrition and better general health conditions.

29 Well, that overlooks the
30 irrefutable fact, quite obvious to any long-term

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1 observer of the Northern scene and Indians and Inuit
2 in particular, that the cash income and material
3 affluence of Indians and even more strikingly so for
4 the Inuit increased many-fold, even after allowing
5 the inflation rate during the last twenty years, but
6 that their nutritional and general health with the
7 exception of ^{the} tuberculosis picture and that naturally
8 is explained by other factors; physical, mental as
9 well as social health suffered greatly during that
10 same period.

11 I should perhaps include here
12 a word of caution which isn't in my text. Much has
13 been said about the need of settling land claims, the
14 land claims issue. I think I agree with everything
15 that was said yesterday in that respect but I would
16 like to put a word of caution in that the land claim,
17 one thinks of settling that with large sums of money
18 to be available to individuals, may actually bring more
19 problems that it would solve.

20 That any such exchange of
21 land for money in the past, we know that this was not
22 favorable to the native people.

23 THE COMMISSIONER: I think I
24 should say that the native organizations that have
25 appeared at the Inquiry have rejected that approach.

26 A I'm very happy to hear
27 this. If pondering the possible or likely impact of the
28 massive influx of men and money for the proposed
29 Mackenzie Pipeline would bring, we would do well to
30 consider how previous events bringing massive influx of

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men and money affected northern natives, such as the Klondike Gold Rush around 1890, the Yukon Indians; the whaling industry at various periods in the second half of the last and first decade of this century, the Inuit in Northern Alaska; the Beaufort Sea, Northern Hudson Bay and Fox Basin in Eastern Arctic, the construction of the Alaskan Highway in World War II, the Northern British Columbia and Yukon Indians and the construction boom of the Mackenzie Highway with the Indians of let's say Ft. Providence and others in that area, and the DEW-line construction '55 to '57 and the Inuit of large belt across the Canadian Arctic.

There's no doubt that in every example just mentioned much more damaging than beneficial effects to the health of native people resulted; but the character and the extent of the damage differed greatly, varying from killing 90% of the original Coastal Eskimos in Northern Alaska and the Mackenzie Delta after the whaling fleets brought the first massive contact from the outside world to much less deadly consequences following DEW-line construction in '55 to '57.

Well, actually between '55 and '57 there was no marked increase in mortality of the Inuit as a whole, although as you remember from that one graph, the infant mortality went up during that period.

The fact that the impact on health and life differed widely at various times and places must caution us not to expect uniform con-

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1
2 sequences in different places and times even if the
3 intrusive factors should be similar. The example of
4 the DEW-line construction impact gives also testimony
5 to the benefit of some preventative and cushioning
6 effects of government action, particularly if it's
7 taken with native consultation, and restrictive
8 regulations resulting thereof.

9 When looking at the various
10 historical examples of large scale outside intrusion
11 into the life of native peoples in the Canadian North,
12 which I mentioned above, and the changing character
13 of impact on their health, it becomes clear that it is
14 less now or practically not at all anymore the lethal
15 effects of new infectious diseases such as measles,
16 smallpox and the slower but longer lasting slow white
17 death, namely tuberculosis which is to be feared but
18 rather the disruption of nutritional balances and
19 patterns, social disintegration and loss of independence
20 and identity and consequent anxiety reactions as
21 yesterday, mental illness as yesterday was outlined,
22 and alcohol related diseases such as accidents,
23 homicide, suicide which I foresee today and which is
24 to be feared and to be guarded against.

25 THE COMMISSIONER: Excuse me,
26 Dr. Schaefer. Before you leave that subject, you said
27 on page 5 that homicide, suicide and other accidents,
28 most of them related to alcohol account for more than
29 30 percent of all deaths of native people in the N. W. T.
30 What would the comparable percentage be for Canada as a

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1
2 whole?

3 A I must apologize not to
4 be able to give you an exact figure, but I believe it
5 would be less than five to ten percent. Can Dr. Hildes
6 help me?

7 WITNESS HILDES: Certainly --

8 WITNESS SCHAEFER: In Canada,
9 as a whole, I believe eighth or ninth in line of
10 leading cause of death, while in the Northwest Territories
11 it is the first.

12 Q And in the Canadian
13 figure, would you include automobile deaths?

14 WITNESS HILDES: Yes, I would.

15 WITNESS SCHAEFER: That would
16 be included.

17 Q So, the comparable rate of--
18 I mean, I'm sure you would include automobile deaths
19 in that category in the N. W. T. but there aren't--

20 A That has to be included
21 but it must be realized that the automobile, the rate
22 of automobile deaths in the Northwest Territories is
23 by the type of territory and sparsity of a road network
24 much less ominent than other things in the North.

25 Q Yes. So, the comparison
26 between 30 percent and whatever it is for Southern
27 Canada might be--
28
29
30

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1

2

A Well --

3

Q -- an even

4

greater disparity if you took automobile deaths for
Southern Canada into account and excluded them, perhaps
you shouldn't, perhaps they really belong.

7

A I maybe could compare

8

this with the Alaskans, I think I have somewhere in

9

my notes. What I propose to do, sir, is I'll take a

10

note of it and send it to you in a letter, the exact

11

rate across Canada; after my rough guess I said it would

12

be between 5 and 10% compared to over 30%.

13

Q Right. All right, thank

14

you.

15

A I have only another

16

two minutes to go, if I may indulge your patience.

17

Q No, I think we're all

18

paying close attention, don't worry. You were on 9.

19

You were about to say, "Lastly --".

20

A Lastly, perhaps, I should

21

address myself to the question, what impact is to be

22

expected from rapid massive development such as the

23

proposed pipeline construction on the quality of health

24

care delivery in the Northwest Territories?

25

From several published studies

26

and I have some in my references, as well as personal

27

enquiries during a visit to Alaska in February of this

28

year, as well as communications received since then

29

from Alaska, several points have become quite clear

30

already about the Alaskan experience.

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(1) The extra load due to illness and accidents on the existing health care facilities in Fairbanks, Anchorage and other centres not necessarily such as Anchorage, directly considered staging areas for the pipeline construction, has been far higher than anticipated and overtaxed facilities and personnel of the health care delivery systems there to the detriment of the pre-boom clients.

(2) There has been a sharp rise of venereal diseases, alcohol-related accidents and violence not confined to newly arrived construction workers, but involving also pre-boom Alaskans and especially native Alaskans, who in addition have experienced another alarming rise in their suicide rate which was in 1974 at the symposium in this town here, described by Dr. Kraus as being of epidemic proportions, and which had doubled in the boom period, that is the Alaska pre-boom period between 1970 and '73 inclusive, had doubled against the period between '65 to '69, and had more than tripled compared to the decade experienced in '55 to '64 which was a relatively quiet period for Alaska.

(3) The higher wages paid by oil industry and contractors involved in pipeline construction have depleted hospitals and other medical services of technical and auxiliary personnel, endangering their efficient functioning and straining their budgets in the attempt to remain competitive. (Our own department, by the way, and other government agencies, have already felt in the last years the pull of the oil industry on their

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1
2 technical and maintenance staff) as people from Inuvik
3 will tell you, from the Inuvik Hospital.

4 In view of the sevenfold larger
5 population base -- I must apologize for that little
6 rough estimate of tenfold in my original writing --
7 it's sevenfold if you look at the exact figures, larger
8 population base^{in Alaska} and a much more advanced and resilient
9 state of political, technical and medical organization
10 in Alaska versus the Northwest Territories, the prospect
11 of being less prepared and more likely to be swamped by
12 the additional load such a mammoth project, if
13 undertaken right now, would place at present on existing
14 medical facilities and personnel are that much greater
15 for the Northwest Territories than they were for Alaska.

16 In summary then, the past
17 events of the Canadian north and present experiences in
18 Alaska with due regard to local differences and changes
19 which occurred with time suggest that the impact of the
20 massive and temporary influx of men and money into the
21 Canadian north as expected and inevitable with the
22 Mackenzie Pipeline construction project at present on
23 the physical, mental and social health of the native
24 population will be great and in my opinion for the most
25 part detrimental. Some, but not complete, cushioning
26 of those effects may be possible by wise restrictions
27 and controls placed in co-operation of government,
28 industry and native groups, and I would say the last
29 group should have the strongest voice in it, on immi-
30 grant workers similarly as was done at the time of the

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DEW Line construction.

Tremendously increased demands and a weakened position in the competitive job market may overtax facilities and personnel available for health care delivery, and decrease the fairly high quality and density of medical care achieved against terrible odds over recent years for natives and other residents alike by medical service and universities involved in the Canadian north.

Thank you very much, Mr.

Commissioner.

THE COMMISSIONER: Thank you,

Dr. Schaefer.

MR. BAYLY: Perhaps we could turn then, Mr. Commissioner, to the presentation of Dr. Mayhall?

THE COMMISSIONER: Yes. Well, let's stop for coffee, and then hear from Dr. Mayhall.

(QUALIFICATIONS & EVIDENCE OF DR. SCHAEFER MARKED EXHIBIT 762)

(SLIDES & PHOTOS RE DR. SCHAEFER'S EVIDENCE MARKED EXHIBIT 763-A)

(ARCTIC OPHTHALMOLOGY SYMPOSIUM REPORT OF DR. SCHAEFER MARKED EXHIBIT 763-B)

(PROCEEDINGS ADJOURNED FOR A FEW MINUTES)

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1 (PROCEEDINGS RESUMED PURSUANT TO ADJOURNMENT)

2 THE COMMISSIONER: Let's begin
3 again, then, shall we?

4 MR. BAYLY: Mr. Commissioner,
5 if we could turn our attention now to the submission of
6 Dr. John Mayhall.

7 Q Dr. Mayhall, could you
8 make your presentation to the Commission, please?

9 WITNESS MAYHALL: Yes, thank
10 you.

11 I welcome the opportunity
12 to testify before this Inquiry because of my strong
13 feelings that when a potentially large project such as
14 the construction of a pipeline and petrochemical
15 development is proposed, all of the potential impacts
16 on society should be considered. One of the concerns
17 of this Inquiry, rightfully, should be the determination
18 of the impact of the proposed petrochemical development
19 in the Mackenzie Valley on the health and well-being
20 of the present residents of that area. Also it seems
21 plausible for the Inquiry to specify the terms and con-
22 ditions under which such development will proceed in or-
23 der to minimize any potential dangers to the health of
24 the present residents and to assist them in obtaining
25 and maintaining a high level of health.

26 In particular, I am concerned
27 with the effects of the influx of machinery, personnel,
28 and money on the oral health of the residents, and
29 once the construction has ceased, the effects of the
30 loss of many of the facilities which might accrue from

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1
2 the construction phase. I think it will become obvious
3 very shortly that I am not in a position to pass a
4 considered judgment on whether a pipeline should be
5 built; but I do feel that I can provide this Inquiry
6 with information demonstrating the disastrous effects
7 of increased contact with semi-isolated groups with
8 modern civilization -- that being in quotes. With the
9 increased contact comes a dietary shift towards
10 processed foods and increased ability to purchase foods
11 deleterious to the individual's health.

12 Before I attempt to outline
13 these effects, let me state that there are large gaps
14 in our knowledge of the oral conditions of the Mackenzie
15 Valley residents. What few figures I have been able
16 to piece together from inadequate, meagre studies
17 indicate that the residents demonstrate approximately
18 the same levels of oral health found in many other
19 regions of the Canadian Arctic and sub-Arctic. Because
20 of the paucity of published oral epidemiological material
21 from the Canadian Arctic, we may never know what effects
22 the pipeline will have and I must enter a plea now for
23 reliable data to be collected to determine the dental care
24 needs of the residents of the Territories.

25 During the past 13 years I have
26 had the rare privilege to be associated with Inuit
27 and Indians in various regions of the Arctic and sub-
28 Arctic and to record their oral health. My introduction
29 to the oral health conditions of the aboriginal peoples
30 of North America began in Alaska where I was a dental

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1
2 officer with United States Public Health Service and
3 treated Indians, Inuit, and Aleuts for ^{three} years. Following
4 this period I obtained further education in dental
5 anthropology and have been during and since that time
6 able to observe the oral health conditions of literally
7 thousands of aboriginal people in Alaska and Canada.
8 My testimony before this Commission will draw from these
9 experiences, as well as from a thorough study of the
10 literature relating to the effects of a changing
11 culture on oral health.

12 Before proceeding further. --
13 yes?

14 THE COMMISSIONER: Excuse me.
15 Just going back for a minute, that word that gave Mr.
16 Bayly so much trouble, epi --

17 A Epidemiology.

18 Q Is that the cause? What's
19 the definition of the word?

20 A Well, it has various
21 definitions, I think, as most things do, but we're
22 talking mainly of the spread -- I'm sorry, the numbers
23 of individuals affected by this disease, that was one
24 part of it; the virulence of a disease; where it's
25 found, the geographical location of it and so forth.
26 So it's sort of looking at oral pathology or pathology
27 in general on a -- to a certain degree on a geographic
28 --

29 Q Where it is to be found?

30 A Excuse me?

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Q Where it is to be found.

A Yes, where it is to be found and what kinds of things are found there, and in what numbers.

Q Right.

A So it's sort of a continuum thing.

Before proceeding further, there are indices which will be basic to my testimony that may not be familiar to the Commission. First, I will be discussing the changes in dental caries. Dental caries or decay, is usually measured by an index which is abbreviated D.M.F.T. This represents decayed, missing, and filled teeth. Once a tooth is decayed, it cannot repair itself, resulting in an extraction which leaves a missing tooth or a restoration and a filled tooth. Obviously then, once a tooth is attacked by the carious process, it will always be recorded as missing or filled or decayed. Deciduous teeth (that's baby teeth) show the same processes except that they are lost by the age of 12. So for the purposes of this testimony I will refer to caries experience, which is a compendium of the teeth that have been attacked to a certain age level. The caries will, in the younger age groups, be a combination of decayed and filled deciduous teeth and decayed, filled and missing permanent teeth.

Other possibilities for identifying the extent of carious attack are the use

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of the percentage of individuals who show signs of involvement, or the percentage of teeth with carious activity. Conversely, I will indicate the number of caries free individuals.

The other major area of oral health which I will be examining is the state of health of the periodontium, familiarly known as the gingiva or the gums. Periodontal health can be recorded by several indices. These indicate the inflammation of the tissues, those which indicate the amount of destruction or those which attempt to gauge overall health of the gingiva and supporting bone involvement.

The cleanliness of the oral cavity can be measured by indices which indicate the amount of debris on the teeth and the deposits of calculus or tartar on the teeth.

With this brief introduction I would like to explore the progression of dental disease in the aboriginal people of North America and to indicate some of the trends which are extant. In the Inuit, dental caries is a comparatively new and recent occurrence. The Thule culture people who inhabited Canada between about 900 A.D. and 1600 A.D. show almost no evidence of decay. These people are the biological precursors of the present-day Inuit. An examination of approximately 500 burials of Thule culture skeletons from the west coast of Hudson Bay revealed only two affected individuals with one small carious lesion each. It turns out these two burials were from

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2 the very late period, and probably represent individuals
3 who had contact with the earliest explorers in the area
4 in the 18th century. We may assume, therefore,
5 that there was little or no access to refined carbo-
6 hydrates or other processed food in the Hudson Bay area
7 until about the 1600s, and that this was the first area
8 of the Canadian Arctic to have been visited by explorers
9 searching for the Northwest Passage. Our knowledge of
10 the oral health of the Inuit between approximately 1700
11 and early 20th century is extremely limited except
12 that many explorers have commented on the ability of
13 the Inuit to use their presumably healthy teeth as a
14 third hand.

15 Indians, on the other hand,
16 have a long history of dental disease. The advent of
17 dental caries coincides closely with the shift from a
18 hunting-gathering subsistence to an agricultural one.
19 In fact, this correlation has been noted so many times
20 that we now use the presence of dental caries to iden-
21 tify agricultural Indian culture. In the case of
22 Southern Canadian Indians it is not unusual to note
23 caries in skeletal material from about 1,000 years
24 ago. In the sub-Arctic area the Indians were lucier
25 from an oral health standpoint in that their sub-
26 sistence remained one of hunting-gathering, or until
27 recently, hunting-trapping. These latter subsistence
28 patterns provided a diet which was less caries producing
29 than the agricultural one

30 In both the Inuit and the

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Indians, periodontal disease does not seem to be evident until the demise of the hunting-gathering-trapping subsistence pattern.

The studies of the progression of dental disease in North American aboriginals began in the late 1920s and the first comprehensive studies were published in the '30s. In 1929 L.M. Waugh visited 20 Alaskan communities and commented that almost without exception the younger people had much worse teeth than the older residents. In only two communities were there no problem with the teeth of the Inuit residents.

The observation that the older individuals who were examined had better teeth than the younger ones will also be noted later. As I mentioned earlier, once a tooth becomes carious it has no way of repairing itself. Thus, in a population one would expect the number of decayed, missing and filled teeth to increase with age if all residents had been exposed to the same environmental conditions throughout their lives, given an identical susceptibility. If the rate of decay is lower in old people than in children and adolescents, we can hypothesize that the reason for the increase in the younger ones is an increase in the oral environment. This change is usually consistent with a change in diet. The younger people had worse teeth because they changed their diet to a more caries-prone one while the older people probably remained on essentially the same diet they had consumed throughout

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their lives.

A 1936 study by W.A. Price utilized the results from 800 examinations of native people from Alaska, the Yukon, Ontario and upper New York State. Price found that ~~these~~ Inuit subsisting -- those Inuit subsisting on food from the land had incidence of dental caries of 0.09%, while those Inuit declared to be "modern", using his terms of reference which are not well-defined, I might add, as to what "modern" meant to him, those people who were modern in dietary, had a 13% of their teeth decayed.

In the Indians, the figures were 0% and 21.5% respectively.

Further, Price considered that some individuals in both the Inuit and Indian groups as having, and I quote, "liberal contact" with modern civilization. Within this group attacked -- within this group caries attacked 30 to 50% of the teeth. Thus in Indians there was an increase of at least 50% in the caries rate, from those who had some contact with Euro-Canadian society to those who had frequent intercourse. Among Inuit, the increase from modern contact to consistent contact was at least 200%.

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Two further studies are worthy of note. The Canadian Arctic Expedition of 1913 to 1918 returned with thirty-four Inuit skulls which were extensively studied by Dr. Stephen Ritchie. He was unable to detect a single instance of dental caries in this material. In 1937 a physician aboard the "Nascopie" examined eighty-two Inuit aged four to sixty-five years at Pangnirtung and found only six individuals with carious teeth. While he did not give the exact caries rate, it is possible to make an accurate estimate of the DMFT of 1.07 per individual. This represents the first instance in Canada, to my knowledge, of an oral epidemiological report which is comparable to modern techniques.

We can see in all of these early studies the same trend emerging, the more contact with European culture, the higher the rate of oral disease in previously isolated Indians and Inuit.

In recent years there has been a resurgence of interest in the effects of nutrition on oral health among the native peoples of Alaska, Canada and Greenland. I propose to examine studies in each of these countries which add to the previous data and lend further strength to the need for preventative measures to be undertaken to curb oral disease.

In Alaska, two papers published by Russell and his co-workers documented the difference in dental caries and periodontal disease between National Guard members from isolated communities and

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2 those from communities which had access to processed
3 food. The 700 Aleuts, Indians and Inuit as a group
4 showed somewhat worse periodontal disease than males
5 studied in Baltimore. No association between signs
6 of past and present, or present periodontal disease and
7 indicators of nutritional status could be demonstrating,
8 leading to the possible hypothesis that periodontal
9 disease was a recent invader in Alaska.

10 This hypothesis is given
11 further credence by a more recent paper by Kristoffersen
12 and Bang who investigated the rapid deterioration of
13 the periodontal health of the residents of Anaktuvuk
14 Pass, Alaska within an eight year period of increased
15 consumption of processed food.

16 The study of dental caries in
17 1958 by Russell and his co-workers were carried out
18 using the same studies, the same subjects sorry, as
19 the periodontal study. One of the first statistics
20 which is obvious is the lowering of the DMFT with
21 increasing age. The men between 17 and 19 years of age
22 had a rate of 10.02 teeth affected per individual, while
23 the older men, those over thirty-four, had a rate of
24 about 6.6 teeth affected. These caries rates were much
25 lower than those for comparable age groups of Baltimore
26 males. In fact, the older men's rate was one-third
27 of that of the Baltimore men of the same age. They
28 discovered that, in general, the closer a man lived
29 to a principal village, the higher his caries rate.

30 Two more recent studies show

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1 the effect of diet on Alaskan Inuit. Bang and
2 Kristoffersen studied the same people mentioned earlier
3 from Anaktuvuk Pass and noted that in the eight to ten
4 year period, after their first examination, the caries
5 rate for primary teeth had increased by 90 percent.

6 The rate for permanent teeth
7 in persons over six years of age increased a four-
8 fold increase. In the over thirty years of age group,
9 a group previously caries free, all individuals had
10 developed caries. Remember that the dietary had shifted
11 toward one composed of much more processed food. In
12 1968, in conjunction with Dr. A. A. Dahlberg and Dr.
13 David Owen, I studied the Inuit of Wainwright, Alaska.
14 We found the caries rate for the residents there to
15 average almost fourteen teeth decayed, missing or
16 filled per individual, a rate which is comparable with
17 the figures for all natives of Alaska.

18 We stated that and I quote,
19 "it was commonly noted that the highest caries rates
20 were exhibited in families that had the higher incomes".
21 L. A. Waugh in 1929 remarked that Wainwright was one
22 of only two communities which had no oral health problem.
23 Thus, in only forty years, the oral health had
24 deteriorated severely. It is interesting to note that
25 at the time of Waugh's examination, the local store
26 was just establishing itself and from that time on,
27 there seems to be an increasing dependence on processed
28 food.

29 The best epidemiological records
30 for the Alaskan natives are compiled each year by the

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Division of Indian Health of the U. S. Public Health Service. If we examine the figures for those individuals most susceptible to dental caries, the under 17 age groups, we find a steady progression in dental disease from 1957 until 1963 when a comprehensive preventive program began. Since then the rates have decreased slightly.

The Greenlanders have been the subject of numerous oral epidemiological studies dating back to 1913. Today untreated caries is four to five times more frequent in Greenland than in Denmark. The overall prevalence is also much higher in Greenlanders. Communities which at one time were considered isolated and showed low caries rates now have the same high rates as other parts of Greenland. To quote Jakobsen and Hansen, "There is no doubt that the increased frequency of caries is due to a steep increase in the consumption of sugar and sweets".

Now, as far as Canada goes while there appear to be no long-term studies of Indians and Inuits living within the same area as were those in Greenland, the area of Northwestern Ontario has been extensively studied recently and those results can be compared with a survey in the same general area. 1947 McIntosh surveyed the Cree Indians of the Ontario coast of Hudson Bay. From this study the children of the Attawapiskat Band had an average of less than three permanent teeth per individual affected by caries.

In a 1973 study that we carried

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2 out of the Sioux Lookout zone of Ontario revealed a
3 caries rate of 5.6 permanent teeth affected among the
4 Cree children. While the two studies are not directly
5 comparable, they do reveal the changes over a short
6 period. The latter study demonstrated that those
7 children living in the larger communities with better
8 transportation and shopping had higher caries rates
9 than those in smaller, generally more isolated
10 communities.

11 A comprehensive study of
12 four Indian communities in British Columbia and the
13 Yukon still further confirms the hypothesis that access
14 to processed foods increases the susceptibility to dental
15 caries and periodontal disease. Myers and Lee examined
16 the dietary records and concluded that, and I quote
17 again, "The evidence seems to indicate some degree
18 of correlation between the consumption of those foods
19 usually associated with the initiation of dental
20 disease", and they point out that these include candy,
21 carbonated beverages, and dessert powders, "and the
22 incidence of dental disease".

23 They also obtained the impression
24 that in the communities with the higher oral disease
25 rates the earned income of the families was higher.
26 The conclusion of their study is more important in
27 planning for future prevention and care of dental
28 disease. I would like to quote them once again.
29 "Although living conditions may appear superficially
30 to be similar, many factors such as genetic constitution,

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2 dietary patterns, and the availability of medical and
3 dental care may influence the conditions of general
4 and oral health found at any particular time period".

5 While reliable published data
6 on the levels of oral pathology in Inuit throughout
7 the Canadian Arctic is scarce, an important paper by
8 McPhail and his co-workers surveyed over five hundred
9 school age children in the Keewatin District of the
10 Northwest Territories. I would like to quote just a
11 portion of the abstract from their paper.

12 "This study confirms that widespread dental
13 caries, severe malocclusion and an alarming
14 prevalence of periodontal disease pose a
15 major public health threat to Canada's central
16 Arctic region. Particularly vulnerable are the
17 Keewatin Eskimos who, while possessing no
18 immunity to tooth decay, must nevertheless
19 learn to cope with imported foods as they
20 gravitate increasingly to pin-point communities
21 because two-thirds of the population are under
22 16, the authors call for immediate remedial
23 action".

24 McPhail and his co-workers
25 compared the non-Inuit residents of the Keewatin with
26 Inuit residents. Over twice as many non-Inuit children
27 were caries free when compared with the Inuit children
28 and the percentages are astounding really. 57.5 versus
29 27.5 percent. Periodontal disease was more than six
30 times more prevalent in Inuit children and of these

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I would like now just to briefly discuss the concepts of the initiation and progress of dental caries in the framework of the effects on the individual tooth and to discuss the role of nutrition on the process.

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This summary comes from a recent symposium on nutrition of Indian and Inuit children.

There is no reason to believe that the nature of dental caries is different from any other human disease in that it is multifactorial. There must be a host, in this case it's the tooth. Resistance to caries depends upon the stability of the inorganic portion of the enamel. The agent in this case is dental plaque which adheres to the tooth surface and contains bacteria and other types of cells in a polysaccharide-protein matrix. Influencing this host-agent relationship is the surrounding environment. The bacteria in the plaque become virulent and proliferate only if there is a low protein high sucrose environment. These virulent bacteria produce an acid which decalcifies the inorganic portion of the enamel, followed by a proteolysis of the organic matrix and invasion of the bacteria which destroy the dentin.

If we now briefly outline the general conclusions of the effect of food on dental caries, I refer you to table 1 of the submission which you have, we can see that there is no easy solution to caries prevention. Dietary proteins and fats appear to be cariostatic. However, this may be because a diet high in proteins and fats will automatically be low in carbohydrates, which are cariogenic.

While carbohydrates are listed

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in the table as cariogenic, there is a wide range in the cariogenicity depending on the form of the carbohydrate. Starch appears to be the least cariogenic and sucrose the most. Refined carbohydrates are implicated in dental caries, while there may be substances in unrefined foods which reduce the solubility of the enamel. There are numerous studies which have shown the cariogenic effect of refined carbohydrates when they are added to a previously non-cariogenic diet.

It is most important to eliminate other factors which accompany -- I'm sorry, it's almost impossible to eliminate other factors which accompany the addition of refined carbohydrates to the diet. Possibly as important as the amount of sucrose ingested are the physical and detergent properties of the diet, and the frequency of ingestion and the oral clearance of ingested food. It should be noted that sucrose containing foods of a sticky consistency are more cariogenic than those which pass through the oral cavity quickly. It has also been hypothesized that foods of firm consistency contribute to the cleansing of the teeth and result in a reduction of plaque when compared with a soft diet. But I feel that these relationships may not be as simple as previously suggested. You may note that the word "not" was deleted inadvertently from your text.

The etiology of periodontal disease is much more difficult to assess because

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-- excuse me?

THE COMMISSIONER: Etiology,
how do you define that?

A The cause, I would say,
would be a suitable term here.

The etiology of periodontal
disease is much more difficult to assess because
several possible different conditions are included
within this category. Goose and Hartles noted that
soft foods are detrimental because they provide no
stimulation to the gums and they foster an accumulation
of irritating food debris in the crevices around the
tooth. This debris accumulation fosters the growth
of bacteria which may cause the inflammation of the
gums. Calculus which accumulates on the teeth also
acts as an irritant. Further, if the teeth are not
well-aligned or are in malocclusion, normal function
of the teeth may be precluded and stagnation of food
can occur with subsequent irritation and breakdown
of the gingival tissues.

Since 1972 my colleagues and
I have collected observations on over 3,000 Cree and
Ojibway residents of the Northwestern Ontario region
and at present are intensively studying the oral con-
ditions of the school children of that area. Many
of the same patterns of disease noted earlier are
evident in this area as well. The number of teeth
affected by dental caries rises from the eruption of
the permanent teeth in the mouth until about age 40.

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2 After this we find a reduction in the DMFT. Again
3 this probably indicates a change in dietary patterns
4 between the older residents and the younger ones.
5 Certainly the most susceptible groups are the pre-
6 school and teenage residents. In those children
7 under 11 years of age we find that almost one-half
8 of the children's teeth have been or are decayed. As
9 I noted earlier, those children living in the more
10 remote areas, some of which had no commercial outlet
11 for food, tended to have the better teeth. One is
12 struck when living in the communities of Northwestern
13 Ontario by the high demand for dental care. While in
14 southern communities adults and children are usually
15 reluctant to visit the dentist, in the isolated communi-
16 ties the result is the opposite. When it is ascertained
17 that a dentist is in the area, the dentist will be
18 unable to cope with only those people who want to be
19 seen, while having to ignore the more reluctant people
20 who do not vigorously pursue an appointment.

21 Between 1968 and '73 I was
22 part of a multidisciplinary study of the INuit of the
23 northern Foxe Basin as a part of the human adaptability
24 section of the International Biological program;
25 included in this program were Dr. Schaefer and Dr.

26 Hildes. The two principal communities in the area,
27 Igloolik and Hall Beach, were visited each year over
28 the five-year period by a team of investigators who
29 ascertained the nutritional status of the residents,
30 their growth, the physical health, and their dental health.

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This period was a time of rapid change in the lifestyle in the area. In 1968 Igloolik was an isolated settlement with few people holding jobs. To reach Igloolik one was forced to fly to Hall Beach and then travel the final 60 miles in a canoe or tracked snow vehicle. Hall Beach, on the other hand, was close to a DEW Line site which provided regular wage employment for some. By 1973, the time of the last examination, both communities had twice-weekly air service to Frobisher Bay where you could board a jet to Montreal. Thus in 1968 there were a higher percentage of family heads employed in Hall Beach. By 1973 these differences were obliterated. Igloolik had become an administrative centre, and the chances for wage employment for the Inuit were greatly expanded, along with the opportunity to purchase large amounts of processed food. Hall Beach displayed a decrease in wage employment due to a phase-out of the DEW Line site employment opportunities for the Inuit with a concomitant decrease in access to southern Canadian foods.

In 1969 when parents were questioned about their children's dietary habits, they indicated that the children were consuming essentially the same food as they. But by 1973 almost all parents noted that their children were subsisting primarily on commercial food, and that if money was available, enormous quantities of soft drinks and candies were consumed. In fact, it was in these

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2 caries prone age groups that the most dramatic shifts .
3 in diet from a native type to a commercial type foods
4 were noted, and this is outlined briefly in figure 1.

5 In 1969 the results of the
6 oral examination were divided into groups representing
7 the percentage of native food in the diet and caries
8 experience computed. As can be seen in figure 2, of
9 the submission, those individuals consuming primarily
10 processed food had a caries rate over four times
11 higher than did those who were living off the land and
12 the sea. The results of the 1973 examinations were
13 compared with the 1969 data, with sobering results.

14 In a period of only four
15 years, the caries rate had increased overall by 66%
16 and I think you can see from a very quick perusal of
17 tables 2 and 3 that in general, the more acculturated
18 the group, the higher the dental caries rate, and I
19 would bring to your attention there also the rates
20 especially for younger people, the tremendous increases
21 that occurred in those susceptible groups.

22 Hall Beach, with more contact
23 with southern Canadian culture, had a higher rate in
24 '69, but by '73 Igloolik was rapidly approaching the
25 increasing rate of Hall Beach. Here for probably the
26 first time we have cross-sectional and longitudinal
27 evidence of the effect of dietary shifts towards
28 processed food on the caries rate, and a genetically
29 identical group.

30 Periodontal conditions were

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2 also studied during the four-year study period. In
3 contrast to the study of Kristofferson and Bang, we
4 found little differences in the periodontal disease
5 levels of the Foxe Basin residents, and I can only
6 hypothesize that this is because periodontal disease
7 seems to be a much slower process and also it's a
8 little harder to quantify. It takes much more
9 gross quantification to identify it, and so we don't
10 expect to see the levels that we find in Alaska for
11 some time yet. But I think that they're coming.

12 At this stage I'd like to
13 provide some personal observations, I think, which
14 are germane to this Inquiry.

15 As I noted earlier, I was
16 employed by the US. Public Health Service from '63
17 to '66, as a dentist, treating the native children
18 of Alaska.
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2 I was, and still am appalled
3 by the overwhelming need for dental care among the
4 native people of North America. It is no exaggeration
5 to say that there is already an epidemic of dental
6 disease among the native people. One of the reasons
7 for leaving the practice of dentistry in the North
8 was the depressing never-ending procession of children
9 and adults with rampant, untreated caries. It seemed
10 that everyday there were more people in even worse
11 condition needing care.

12 When I first went to Igloolik
13 I told Dr. Schaefer that the people there were not
14 in need of dental care on any major level. Four years
15 later I told him that now they were in desperate need
16 of dental care, at which time he reminded me of my
17 previous statement. I reaffirmed my feeling that the
18 Inuit of Igloolik needed a dentist badly, but his
19 reminder of my previous comment pointed out to me the
20 tremendous increases in dental disease in just four
21 year.

22 While I have presented many
23 studies and many numbers which indicate the condition
24 of the teeth of the Indians and Inuit, they only
25 remove one from the pain and disfigurement from
26 rotting teeth which an individual must endure because
27 of the inadequate facilities, manpower and planning
28 in the past, and a lack of prevention and concern
29 now. The solution to many social and health problems
30 of providing employment and higher incomes will not

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benefit the dental health of the native people. In fact, it will have the opposite effect.

I want to talk a little bit about dental morphology and as I point out, this may seem rather far removed from the discussion of the effects of culture change on oral disease. However, I think I can convince you the tooth shape of the people we're dealing with here is crucial to the understanding of many of the problems elucidated so far. In a paper published in 1972 I pointed out that Indians and Inuit have teeth which are more prone to caries attack than are Caucasians. I would like to reemphasize some of the points and to relate the tooth shape to periodontal disease also. My reasons for doing this are to demonstrate that the aboriginal people are more prone to oral disease than the general southern population.

THE COMMISSIONER: Excuse me, Dr. Mayhall. I was going to ask you that. If you had two control groups and one, white children from Vancouver or some place and another, Inuit children from anywhere in the Inuit communities and you subjected them to the same diet of processed food, I inferred from all which has gone before that you would have a much greater rate of caries among the Inuit children than among the white children.

A Yes, I would agree with that. That certainly seems to be the case. I think that this is pointed out by the study I mentioned earlier

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2 of McPhail and co-workers where they were looking
3 at residents living in the Keewatin, both Inuit and
4 non-Inuit, and noting the higher rate. We realize
5 that that may not be a fair comparison because of the
6 fact that probably there were differences in care
7 also of these groups. Certainly we can't separate
8 out any one factor which contributes to this high
9 rate but I think ^{as} we'll see certainly morphology
10 has something to do with it because of built-in food
11 traps in the teeth of Inuit.

12 Q You're about to point
13 out why the shape of the teeth has a lot of do with
14 this.

15 A Yes.

16 Q And maybe you'll come
17 to this but somewhere in there you had an extract from
18 two people who'd written a paper and at the end they
19 said the authors therefore demand immediate remedial
20 measures.

21 A Yes.

22 Q What went through my
23 mind was what can you do? The only remedial measure
24 would have to do with the nature of the diet in light
25 of all that you've said presumably.

26 A Thinking in the terms that
27 I think the authors of those two papers, McPhail and
28 his co-workers were, I think they were thinking mainly
29 in dental terms rather than nutritional terms at that
30 stage of the game. What they were hoping was that there

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1 would be increased care, for one thing, that these
2 lesions which were already there would be repaired
3 and also concomitant with that and probably more
4 important that there would be some initiation of a
5 preventative program. Now, this I think as we'll see
6 later involves a lot of things. Certainly one of the
7 things would be topical fluoride treatments, increased
8 prevention through better oral hygiene, nutrition
9 counselling, a lot of these things. I think this is
10 what they had in mind and there isn't a single
11 approach to it. It's a much larger approach and it
12 effects all people of the North.

13 I'm just saying here that the
14 aboriginal people or North America seem to be more
15 prone to caries but that doesn't negate the fact that
16 all groups are susceptible to it, especially in the
17 teenage adolescent and children. For this
18 reason the same effects accrue to everyone. It just
19 happens that they seem to be much stronger in Inuit
20 and Indian children.

21 Q Okay. Let me just ask
22 you one other question and you're probably going to
23 answer this in the pages ahead but it isn't a situation
24 where after a period of generations of experience with
25 processed foods, Inuit and Indian people would develop
26 some kind of immunity to this drastic rate of caries.
27 You say the problem lies so far as it is inherent in
28 the shape of the tooth. That's the principal thing
29 and that, of course, would pass on from one generation
30 to the next.

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2 A Yes, I think that's true.
3 Maybe I'm over-emphasizing the shape of the teeth.
4 The whole thing of immunity is one which is a very
5 difficult one to deal with because we've not been able
6 to determine why some people, even though they never
7 brush their teeth, for instance, they subsist on foods
8 which we would consider as being prone to promote
9 decay and never develop cavaties. We just don't know
10 why this is and we don't know that much about immunity.
11 So, I'm looking at it in a much broader sense of
12 immunity.

13 As far as that goes, I would
14 anticipate that there would be very little change in
15 tooth shape over any near time. The tooth shape that
16 we see has evolved through a long process of selection
17 and so forth over a thousand years.

18 Q We'd have to--alterations
19 in the tooth shape is not something we can plan.

20 A No, we're not quite
21 that far along. No, unfortunately we can't at this
22 stage of the game or maybe fortunately, I'm not sure.

23 The most common characteristic
24 that's found in the dentition of Indian and Inuit
25 people is the shovel-shaped incisor. This is where
26 the back of the front teeth display a build-up of the
27 sides which when you view it from the back makes the
28 tooth resemble a shovel in shape. It is found in
29 almost all Indians and Inuits but it is more heavily
30 developed in Indians.

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2 This build-up of the ridges confers extra strength
3 to the teeth and was, in all probability, an asset
4 when people were using their teeth heavily. However,
5 with the shift to a cariogenic diet of soft processed
6 foods, we find that the junction of these built-up
7 ridges act as a food trap. Initially, there's only
8 a small cavity apparent at this confluence but when
9 one begins to remove the decay from this area, it's
10 frequently found that this small cavity has spread
11 extensively inside the tooth.

12 In many cases, the pulp of
13 the tooth is affected with adverse results. The
14 heavy development of the ridges on these teeth also
15 make detection of cavities between the teeth more
16 difficult because the tell tale shadow of the cavity
17 is not apparent until the cavity has become enlarged.

18 Q Excuse me. I know it
19 sounds stupid. What are the incisors again?

20 A The four front teeth,
21 upper and lower. So, there's four up above and four
22 down below. They're the ones that you see immediately
23 in front from the midline.

24 In many Inuit and Eskimos
25 there are pits on the cheek surface of the molars.
26 This is the most--the back three teeth which are large
27 and deep and thus prone to food entrapments. As if
28 this weren't enough, many of these pits have no
29 enamel lining and the enamel is the outside portion
30 of the tooth which is the strongest portion and the

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2 most protective. Instead these pits will have a much
3 softer dentin lining within them. It is not unusual
4 to examine a child who has teeth with these pits which
5 have only recently been exposed to the oral cavity
6 through eruption and to find that they're already
7 extensively decayed.

8 In a large number of people
9 this is the first site of attack by caries. In
10 addition to the enamelless pits, the molars of
11 Inuit and Eskimos have a much more efficient pattern
12 of grooves and cusps on their biting surfaces. However,
13 the complicated pattern includes more grooves and
14 fissures than are found on Caucasians with a
15 resultant higher susceptibility to caries. Lower first
16 molars present one further feature which increases
17 their susceptibility to periodontal disease. While
18 most lower molars have two roots, many Indians and
19 Inuit display three roots which increase the chance
20 of food entrapment and subsequent periodontol disease.
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2 Almost all isolated perio-
3 dental pockets -- and this is the thing which usually
4 initiates periodontal disease --have an extension
5 of the enamel from the crown to the root surface
6 associated with them. This extension creates the
7 pocket and so food becomes entrapped in there, breaks
8 down, and we have periodontal disease beginning, and
9 this extension is found in a large proportion of
10 the lower molars.

11 The foregoing review of what
12 may be considered as unusual occurrences in Caucasians
13 are in fact common in Inuit and Indians and are at
14 least partially responsible for their increased suscep-
15 tibility to oral disease with a change in diet from one
16 composed primarily of meat to a processed one. Because
17 of their special dental morphology, they require more
18 intensive treatment and preventative measures.

19 I am assuming that there will
20 be continued oil and gas exploration in the Arctic for
21 some time to come, and that the demand from southern
22 consumers will continue to increase. These factors
23 seem to pretend the maintenance and construction of
24 some type of pipeline to convey the petroleum to
25 market. Given these assumptions and the Alaskan exper-
26 ience, it seems inevitable that there will be increased
27 contact with people from the southern part of the
28 country. This influx of people and supplies will
29 also bring increased demands for packaged processed
30 foods. The opportunities for employment of INuit and

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2 Indian workers will provide more money to purchase
3 cariogenic foods.

4 We can make some predictions
5 based on past experience about the future levels of
6 oral disease, given the fact that no major preventative
7 program seems on the horizon. We have seen that before
8 contact with European culture, dental disease was unknown
9 in the Inuit; in Indians it surfaced at the time that
10 it changed to an agricultural society. However, in
11 both of these populations, the levels remained low
12 until a time of intense contact with European society.
13 For instance, the Thule culture people showed no evidence
14 of caries. Pangnirtung had only low levels in 1937.
15 Foxe Basin residents had intermediate levels, but they
16 are increasing very rapidly with the availability of
17 wage employment. In Alaska where there has been a
18 relatively long period of contact, the levels of
19 disease are extremely high.

20 It does not seem frivolous at
21 all to predict levels of disease equal to or exceeding
22 those in Alaska for our native residents. In fact,
23 I'm sure that in some areas these levels may have been
24 reached already.

25 I must reiterate once again
26 the effects of increased contact on my Inuit and
27 Indians with Euro-Canadian culture. The trend seems
28 to be that isolated or semi-isolated people everywhere
29 desire the glorious accoutrements of southern society.
30 As a consequence of increased contact with the south,

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2 a heavy demand is created for items which will
3 rapidly change the lifestyle of the isolated groups.
4 Community changes can probably be characterized as
5 good, but certainly some are known to produce disas-
6 trous results in susceptible people. I have already
7 noted the calamitous results of refined carbohydrates
8 on oral health.

9 If each of us analyzes what
10 our children do when given a small amount of money,
11 we see that it is often spent on refined carbohydrates.
12 It is not surprising, then, that Indian and Inuit
13 children spend large amounts of money at the Co-Ops
14 or Bay stores for candy and colas. This practice
15 is perpetuated by some stores by giving bubble gum or
16 candy as change. My point is that increased accessi-
17 bility to cash, that with increase accessibility to
18 cash, more cariogenic food will be purchased and
19 consumed. With the increased family income we can
20 expect much higher oral pathology rates, with increased
21 demands for care. Since the dental programs presently
22 under way in the north cannot cope with the problem
23 now, how can we expect any improvement without increased
24 involvement of the profession?

25 At the present time govern-
26 mental dental services are overwhelmed due to the lack
27 of funds and personnel. Only rudimentary preventative
28 programs are in use in Canada. While the United
29 States has launched large-scale programs for their
30 native people, we can hypothesize that with construction

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2 of a pipeline there will be an increased demand for
3 dental service. It may already be too late, but we
4 should begin planning for a large influx of people
5 and increased demands from present residents of the
6 area, and concede long-term as well as immediate
7 objectives for the treatment and prevention of dental
8 disease.

9 Any notion that the influx
10 of additional personnel into the area will attract
11 more and better dental personnel is ludicrous. One
12 has only to examine the number of advertisements in
13 any dental journal for dentists to practice in small
14 communities with good facilities to realize that
15 generally dentists are not attracted to isolated
16 areas, except for short periods of time. I should
17 point out here that over the last year in the
18 American Dental Association Journal there has been an
19 ad in each month's issue by the Teamsters Local of
20 Anchorage in Alaska to try to recruit dentists to
21 go to Alaska. Now, I assume since the ad is still
22 running that there must be some kind of recruitment
23 problems or else they wouldn't -- there hasn't been a
24 mass influx of dentists, obviously.

25 Further, I would hope that
26 after the construction period is over, the local Indians
27 and Inuit will not be forgotten and left to sort out
28 the problems which have remained. This prompts me
29 to propose some alternatives to the love-em and leave-
30 em approach which has been the rule on many developments.

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(1) Any planning of dental health should actively involve the Inuit and Indians of the area, since there is every reason to believe that the construction of pipeline facilities will not last indefinitely and that the oil and gas reserves will eventually be exhausted, a long-term plan for oral health must be devised which will take into account the possible retreat from the area of all pipeline-associated personnel and facilities. It therefore seems imperative to set aside a small amount of any royalties accruing from the resource development for a trust fund which will ensure future oral health care. This has been done in Alaska and several communities are now completely administering their health needs.

I do not think it's realistic to expect the government to provide all the funds for dental care for native people, even though it may be their responsibility. The history of such arrangements demonstrates the fluctuation in the priority given to dental care. Therefore, this trust fund should be used in conjunction with government expenditures to provide a high level of care.

When discussing the future need, we must be cognizant that the first priority is not treatment but prevention. The prevention of oral disease must combine education of children and adults in the area, training of periodontal personnel, dentists and associated workers, adequate facilities and proper dietary counselling. As Jenny and her co-workers have

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recently pointed out, and I quote:

"Efforts to improve children's oral health primarily through educational programs may be less than adequate if current treatment services are not provided."

They also note that community and family factors are very important in influencing the child's oral health. So we must construct an all-encompassing oral health prevention, education and treatment program in the very near future to be able to cope with the impending rapid increase in oral disease. This program must be conceived and financed so that it will be self-sufficient after the exhaustion of the petroleum reserve.

Thank you.

MR. BAYLY: Mr. Commissioner, I propose now to ask you to turn to the paper by Gaile Noble and Gaile, would you read your presentation into the record of the Inquiry?

WITNESS NOBLE : Pardon?

Q Would you read the presentation into the record?

A Mr. Berger, I have already outlined my past employment and education in previous testimony but in speaking to you concerning health and social services in the Western Arctic I would like to elaborate on two parts of my past experience.

THE COMMISSIONER: Excuse me, you might pull the microphone closer to you.

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A I worked in Chile for three years with Servicio Nacional de Salud (the National Health Service) and the Mapuche people of Cautin Province in the delivery of health care services in isolated rural areas. In the N.W.T. I have been continuously involved with health and welfare programs in Inuvik and in the settlement nursing stations since 1973, first as a social development supervisor in the central Mackenzie, and secondly as a social consultant with COPE in the delta communities.

An area of considerable concern to the residents of the north delta in considering the onslaught of intense and rapid development such as a pipeline would entail is the inter-related impacts upon health, mental health, and social welfare of those who have their homes there. I cannot speak to you as an expert in health or in hospital administration, but I can talk to you about some of the concerns of residents here both white and native and some of the social aspects of health care, including the involvement of and consultation with native residents in the health and social services designed to serve them.

Since well before your Inquiry, Mr. Berger, COPE has been concerned with social and health problems of people here, and the services to meet them. I speak of both social and health problems because they cannot be separated. Alcohol is in one sense social. It is also medical in terms

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2 of the affect upon health and mental health. Rotten
3 teeth are in one sense medical, and in the field of
4 dentistry but they are also social having to do with
5 peoples' diet and personal dental hygiene. Venereal
6 disease is certainly medical in one sense, but it is
7 also social having to do with how people live,
8 Respiratory diseases and pneumonia are medical but
9 they are also social in terms of the adequacy of hous-
10 ing in which people live, over-crowding, heating
11 conditions, and so on.
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2 The same is true of death,
3 by accidents, violence and suicide, the number one
4 killer in the N. W. T. as Dr. Schaefer pointed out.
5 However, the services designed to meet these problems
6 are divided among a number of different departments
7 of government. Principally between the Government
8 of the Northwest Territories and Federal National
9 Health and Welfare.

10 I will return to this
11 division of responsibility later in my testimony as
12 it is of some importance, not only in terms of the
13 present social and health situation in the Western
14 Arctic but in the planning for and dealing with the
15 impacts of the pipeline.

16 Until this past year, 1975,
17 there's been little or no involvement of native
18 people in health and social services in the Inuvik
19 zone except as lower echelon employees although there
20 has been much lip-service paid to the need for
21 regular consultation and involvement of people in
22 these services. I might add the same applies to
23 non-native people in Inuvik.

24 In January of 1975, Sam
25 Raddi, the COPE President and residents from Inuvik
26 and settlements met with the honourable Mark LaLonde,
27 Minister of National Health and Welfare. Also there
28 was Dr. J. Colvill, Director of Northern Medical
29 Services and Dr. Mike Connally, who was the former
30 Inuvik Zone Director. This was following an attempt

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2 by the Zone Director to initiate a Citizens Advisory
3 Committee which failed due to his lack of understanding
4 of and consultation with the native communities in the
5 zone.

6 I might just add the Inuvik
7 Zone covers all the settlements from Sachs Harbour
8 down to Ft. Franklin, Ft. Norman and it goes as far
9 east as Paulatuk.

10 At this time, a brief was
11 presented to ^{the} Minister and his staff outlining
12 current problems of health and social service delivery
13 systems as perceived by the people who live there.
14 Besides these problems, the brief also outlined
15 concerns about the impact of a proposed Mackenzie
16 Valley Gas Pipeline and what efforts were being made
17 to assess these impacts and planning for them.

18 I have included a copy of
19 that brief with your paper and one for the Commission.
20 I will not go into the specific problem areas cited
21 in this brief as my concern at this point is how it
22 was handled by Health and Welfare.

23 The response came in two
24 letters from Dr. Colvill to Sam Raddi dated February
25 28, 1975 and a second one on April 7, 1975. In essence,
26 Dr. Colvill stated that he could not substantiate
27 any of the complaints made in the brief after consulting
28 with his staff but if Mr. Raddi could be more specific
29 in terms of names, dates, places and so on, he would
30 try to follow it up. In brackets, some of these

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specifics concerned failure to meet native patients of the Edmonton airport where they're being sent out for treatment, failure to notify relatives by agencies involved in the patient's care and his or her return from Edmonton and so on.

The larger questions contained in that brief, the lack of consultation and involvement of native people in their own health care, the lack of understanding and lack of orientation of medical personnel to native people and their culture, the uncoordinated and divided services between the Territorial Government and Federal Health and Welfare, alcohol treatment and rehabilitation, the impact of the Mackenzie Valley Pipeline; these were merely ignored or politely dismissed as something people of goodwill on all sides could resolve.

The feeling of the people who had written that brief and I was there during this meeting, was that once more they were being ignored, that their honest concerns were simply being dismissed because they were not professionals and they had no power to influence Health and Welfare to take them seriously.

As a result, COPE hired George Wenzel, an Anthropologist now with the Department of Geography at McGill University with previous experience in the eastern Arctic, to document the concerns expressed in COPE's brief for presentation to your Inquiry.

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2 I have enclosed there a copy of Mr. Wenzel's report
3 entitled, "Resident's Perceptions of a Health Delivery
4 System in Six Settlements in the Inuvik Zone, N. W. T."

5 Mr. Wenzel is quite aware
6 of the limitations of this study, given the
7 restrictions of time and money which COPE had
8 available, as Health and Welfare indicated no apparent
9 interest or concern in investigating the problems
10 residents had outlined. Mr. Wenzel interviewed
11 132 people, including Inuit, Dene, and white residents
12 in Inuvik, Aklavik, Tuktoyaktuk, Sachs Harbour,
13 Paulatuk and North Star Harbour. He also interviewed
14 personnel of National Health and Welfare and the
15 Department of Social Development in Inuvik and
16 Yellowknife. As well, both Mr. Wenzel and myself
17 by phone or in person interviewed health and mental
18 health personnel in Alaska, specifically in Barrow,
19 Fairbanks, and Anchorage and Stephens Village.

20 Before going into the
21 specific concerns and recommendations of Mr. Wenzel
22 and myself, both in terms of meeting pipeline impacts
23 and the improvement of the present level of social
24 and health services, let me lay out very briefly what
25 we found in Alaska in relation to pipeline impacts
26 upon health, as well as the current situation in the
27 N. W. T. with regards to health.

28 Expert witnesses from Alaska
29 which should be coming next week for COPE, as well as
30 the experts you have here today, have and will be

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2 delivering evidence in much more detail with the
3 experience and expertise that I do not have.

4 Two specific problem areas
5 associated with pipeline impact in Alaska are alcohol
6 and mental health with significant increases in the
7 number of accident and violence-related injuries and
8 deaths as well as suicides, much of them alcohol-
9 related. This information was obtained from health
10 personnel in Barrow. There has also been a signifi-
11 cant increase in the use of drugs, marijuana, cocaine,
12 hashish, and hallucinogens. With the increase of the
13 non-native population in the North Slope Borough since
14 1970, the load upon the Barrow Hospital has increased
15 greatly. Venereal disease has increased and in this
16 past year they've had their first cases of syphilis.

17 The health problems and
18 mental health problems in Barrow are in turn aggravated
19 by unsanitary living conditions involving poor and
20 overcrowded housing, inadequate water supply,
21 inadequate garbage and sewage disposal. The advice
22 of the Barrow health personnel: "be prepared".

23 When we were over there we
24 had to spend forty-five dollars a night to stay at
25 the Top Of The World Hotel and we had no water and
26 no coffee and nothing to wash your hands with or
27 flush the johns. It was cleaned out once every two
28 days.

29 As for the N. W. T., the
30 health and mental health panels invited by COPE have

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2 outlining the current situation of residents here.
3 I only wish to point out that the current health and
4 mental health problems experienced in the N. W. T.
5 as outlined in the 1973 and 1974 reports on health
6 conditions are in large measure socially based. The
7 major cause of death--well, we've already spoken to
8 that, is death due to injuries, accidents and
9 violence.

10 V. D. is exceptionally high
11 in the N. W. T. as are the number of respiratory
12 infections. Infant deaths are substantially above
13 that of all Canada. The state of teeth you have
14 heard about. In the words of Dr. Colvill in a letter
15 to Sam Raddi dated December 6, 1974 and I quote,

16 "It is obvious that the present health problems
17 are associated with the way in which people
18 live. It can only be corrected by a concentrated
19 effort on the part of the communities and the
20 northern health services working together. To
21 this end, it is essential that the local
22 representatives of the people assume their
23 responsibilities in the planning and implementing
24 of health care delivery programs, particularly
25 in the area of prevention".

26 A second aspect of this
27 health picture is the physical environment, the provision
28 of and adequacy of housing, water supply, sewerage
29 and waste disposal. I'm not an expert on environmental
30 health but in the studies of health conditions in the

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2 N. W. T. I've seen, there's a close relationship
3 between the inadequate conditions of housing,
4 environmental health services and current health
5 problems.

6 In other words, what we are
7 looking at is the health picture in which current
8 disease and social problems are directly related
9 to rapidly changing living conditions, diet, housing,
10 et cetera. Some might question whether Mr. Wenzel's
11 subject, the residents' perceptions of health delivery
12 services has much to do with health care of the impacts
13 of the pipeline. It most certainly does.

14 He identifies two major
15 problems with the health care in the area.

16 "The first is that the system is perceived to
17 be qualitatively inadequate to meet the needs
18 of the people. The second major area is the
19 view held by the majority of the native
20 respondents that the present health care system
21 is unresponsive to their needs. The rigid
22 scheduling, red tape, and the lack of community
23 contact are seen as negative elements of a
24 health care system. High and rapid turnover
25 of staff promotes the view that medical
26 personnel are not interested in the native
27 people and their problems".

28 If people feel that the
29 services are inadequate, that the medical establishment
30 has little interest in their concerns, it is questionable

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how effective these services are, particularly in the preventative and public health areas where understanding, education and communication are essential.

Unfortunately in my experience with both the medical staff and the administration of the Inuvik Zone, the attitude all too often has been the services are there if the people want to use them. There was no consideration of the factors of language, culture, education and previous experience with southern imposed institutions.

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Mr. Wenzel's recommendations are contained on page 3. The first two are:

"That the agencies most involved with health care institute educational programs for their personnel on the cultures of the area," and "that National Health & Welfare begin wider public health programming outside existing settlement facilities in the form of home visiting."

These recommendations go hand in hand in terms of increased understanding and communication by medical staff and the residents in the zone. From what I understand in conversations with health and welfare administrators, recruitment of medical personnel to work in the north is difficult. Rather than screening candidates for their suitability for working in northern conditions and native society, doctors and nurses arrive quite often with little or no preparation, save their credentials, and are left to work out an adjustment individually. This creates large problems in communications, misunderstandings between staff and patients, and frustration on either side. An example is the settlement nursing stations staffed by one or more registered nurses. As a social worker I've had to spend considerable time with some nurses who felt frustrated and at odds with the native community almost to the point of a nervous breakdown. This is not to blame individual nurses at all, but they had not been provided any help in understanding the social and

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2 cultural situation in which they would find themselves.

3 As Mr. Wenzel puts it,

4 "Without an appreciation of the fact that
5 the Dene and Inuit of the area are not southern
6 Canadians, very little can be done to improve
7 the health care establishment's relationship
8 with the people it is in place to serve."

9 The second recommendation stems
10 from what residents themselves expressed and the
11 higher satisfaction he found in the communities of Tuk
12 and Sachs Harbour where home visiting is regularly
13 carried out. Now this may seem a simple matter but
14 it is important to people who are not used to large
15 impersonal bureaucracies in the south and who are
16 not aggressive in voicing their complaints and extreme-
17 ly reluctant to say they do not understand. As the
18 report points out, the personal relationship with the
19 doctor and nurse is of key importance and the basis
20 of confidence which people must have if they are to
21 express themselves and understand what is being done
22 to them and prescribed for them, whether it is in
23 the nursing station or the hospital.

24 Whether the administration of
25 health and welfare consider this of importance is
26 another matter. Some doctors and nurses make a real
27 effort to get out in the community and know the
28 people, while others stay enclosed in the hospital
29 and nursing stations, and the non-native community.

30 There should be a concerted

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effort in conjunction with the native associations and communities to establish orientation programs for the medical staff and establish a policy of home visiting. This is of importance not only for consumer satisfaction, but for effective medical care and the understanding necessary for public health and preventive education.

This ties in to Mr. Wenzel's fourth recommendation:

"That native people be encouraged to take part in all facets of the health establishment within the zone."

A start could be Community Advisory Committees both in Inuvik and in the settlements which have been talked about for over a year but has never gotten off the ground. This is not going to be easy and it is going to take time and encouragement from health and welfare. You don't simply walk out and say, "Establish a Health Advisory Committee." As I know you've heard from many people, Mr. Berger, native involvement in the political, social, educational, economic institutions of the N.W.T. has been neither encouraged nor welcomed the same is true of health care. People have been made to feel that they know nothing, that there is nothing they can contribute to their health and that of their communities, and that it's completely the responsibility of doctors and nurses with their mysterious needles and pills. This should be started now, and it's going to take some change of attitude by

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and education of the medical personnel themselves.
In the North Slope Borough, such Community Advisory
Committees have been established but the impacts of
the pipeline have impeded their success. Mr. Bob
Worl of the North Slope Borough's Health Planning
Department (who will be here next week) can elaborate
upon these impacts when he speaks to you, but one of
the problems mentioned was that of the Advisory
Committees. People had never been involved before
in their own health programs and public health
education had been nil, so it has been a slow educa-
tive process and has been hampered because nobody
is in town, they're off on the pipeline or related
jobs that have developed.

Another area of need within
the Inuvik Hospital and nursing stations are native
interpreters who could also function as liaison per-
sons between medical staff and native patients.
As Mr. Wenzel's report documents -- and this was
also said in the COPE brief -- native patients
frequently do not understand the medical terminology
and instructions given them at the hospital. Where
interpreters are needed, they are drawn in from other
native staff in the hospital, usually housekeeping
or kitchen staff, who have no training in translation
and certainly not complicated medical explanations.
I might add there's been various people in Inuvik,
both Inuit and Dene, who have volunteered to the
hospital frequently and would be glad to come down

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2 and help out. They have never been invited to do so.
3 Frequently patients in the hospital who speak conver-
4 sational English are embarrassed to admit their lack
5 of understanding and are not aggressive enough to
6 seek out explanations from the nurses or doctors.
7 Health and welfare should begin a regular interpreter
8 service within the hospital as well as in the nursing
9 stations which would involve training of native
10 people and could serve an important social service
11 as well as aiding native people deal with the hospital
12 environment. Another factor is pay levels. As Mr.
13 Wenzel mentioned on page 34, pay scales are now very
14 low for community health/T.B. aides which hampers
15 both recruitment and retention of native northerners.
16 High pipeline wages could make this recruitment and
17 training every more difficult unless the pay scales are
18 raised.

19 Three of Mr. Wenzel's
20 recommendations that tie in together are:

21 "That the Public Health Clinic in downtown
22 Inuvik begin operations as a full-time
23 facility, that wider programs for alcohol
24 abuse be developed by the agencies responsible
25 for health care, and that a mental health
26 program be expanded from the existing frame-
27 work and utilize trained native personnel."

28 As you may remember, Mr.
29 Berger, the Inuvik Hospital is located at the very
30 eastern edge of town which may be convenient for the

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government personnel in the government housing, but not for the majority of native people who live at the other end of Inuvik. There is a full-time Public Health Clinic in the hospital and a part-time Public Health Clinic in the West End, which is supposedly open three hours each weekday afternoon. People in the West End would like that clinic open on a full-time basis for its convenience and location, particularly in the winter when it is hard to walk for a sick person and they may have no money for a taxi.

Mental health and alcohol abuse are two inter-related areas that can be expected to receive significant impacts during pipeline construction and both represent major problems now. However, the present situation in the Inuvik zone is that mental health facilities and personnel as well as facilities and programs for alcohol education, treatment and rehabilitation are almost non-existent. There is no detox centre in Inuvik, no rehab centre, no place to put young people who do not go home because their parents are drunk, no half-way house, no crisis line, no crisis intervention centre. The people who come in contact with residents of alcohol problems, social development officers, doctors, nurses (particularly in the settlement nursing stations) have no training in dealing with alcohol unless they have taken a special interest to pursue it on their own. Both the Department of Social Development of the Territorial

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2 Government, and the National Health & Welfare recognize
3 alcohol as a major factor in the health and social
4 problems they deal with in the zone. if there is
5 no training for their personnel in this area.

6 To point to the need for
7 facilities and programs dealing with alcohol problems
8 is one thing; but equally is the kind of facilities
9 and the kind of programs. Alcohol programs and
10 facilities developed to deal with southern middle-class
11 alcohol problems do not work when applied to the
12 alcohol problems of the northern native person (or the
13 southern native person, for that matter). In the
14 N.W.T. alcohol is also a problem for whites, and to
15 date what facilities and programs have been developed
16 or are being utilized are based largely on southern
17 models. Mr. Don Bruce of the N.W.T. Alcohol Co-
18 Ordinating Council will be talking to you about that,
19 along with Mr. Raddi on Friday. There is literature
20 and experience available in Alberta and the U.S. on
21 the varying effectiveness of alternative treatment
22 and rehabilitation programs among native people that
23 should be utilized. Native people must be involved
24 in the formulation and management of alcohol facili-
25 ties as well as the training of professionals and
26 paraprofessionals who deal with alcohol problems.
27 And this must come before the construction of any
28 pipeline, which means that a considerable investment
29 of time, money and education must be made and made
30 soon.

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Mental health is the responsibility of National Health & Welfare, and as experts in Alaska will tell you, it is now and will be a large problem with pipeline construction. As in the situation of alcohol problems, native mental health problems are frequently quite different than those of a middle-class white population having developed in a very different cultural environment and arising from different pressures. This panel spoke to you about this yesterday. What facilities and programs there are now (National Health & Welfare, the Department of Social Development, the N.W.T. Mental Health Association) are predominantly white-staffed, white-controlled and based on southern models. And as you have heard from psychologists and psychiatrists COPE has invited, many of these programs are irrelevant to the mental health and social problems of native people in the north.

As with alcohol, there are some relevant models to look at in both Canada and the U.S. where native people are developing their own mental health and social programs, and with their own staff. Native people must be involved in developing and implementing their own mental health programs which may be ^{far} less costly and more effective than importing southern-trained psychologists, psychiatrists, and social workers and so on.

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Mr. Wenzel's last
recommendation is:

"That liaison between the Department of
Social Health & Welfare and Social Development
must be strengthened in their roles of trans-
porting patients and facilitating information
flow into the settlements."

The responsibility for health and social services
are, as you know, divided between two governments
and a study done by Gordon Friesen Study entitled,
"Mackenzie River Area Health Care Services,"
publicly available at the Department of Social
Development, states:

"This division has led to a fragmentation of
services and dilution of the most valuable
resources -- manpower and financing."

Having worked with this divided system for over two
years, I can well attest to the problems this creates
with almost two competing empires and constant confusion
over which department has responsibility for what. The
poor patient is frequently caught in between.

I can give you one rather
recent example which happened last fall -- well, it's
not so recent now, and is mentioned in Mr. Wenzel's
study. There are differing provisions made for the
payment of medical care and for transportation of
patients, depending on their status, Indian, Eskimo,
or other. I never did get it straight in my own head

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during my year with Social Development, and it's a source of constant confusion and hostility between Health and Welfare and Social Development, let alone the poor patient. George Wenzel and I were in the COPE office when the acting zone director called me up:

"Gaile, what are you guys going to do with this Inuit kid here from North Star Harbour? The infant is ready for discharge and Social Development refuses to provide for it."

Well, it was my understanding that Social Development has the responsibility for returning Inuit patients in terms of accommodation and transportation to their home settlement after their treatment period. I called up the appropriate regional supervisor of Social Development and was told that:

- (1) The department had no room in its receiving home, nor any vacant foster homes, and
- (2) "It's a medical problem anyway so it's not our responsibility."

North Star Harbour, where you've been, is one of the new outpost camps established under the Territorial Government and to which COPE is a signatory. We looked up the contract and in it the Territorial Government agreed to:

"Medical and social services on an as-needed basis."

Health and Welfare was not a co-signer of the contract.

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When I called back the acting zone director he had never heard of it, either the contract or the outpost camp. We then went to the director of the N.W.T. Health Care Plan within the Department of Social Development in Yellowknife and his opinion, without looking at the contract, was that his department was responsible for the care of that child upon discharge and her transportation home. In any case, the hospital did not throw the child in the street, and she returned home on a COPE charter.

We were severely criticized by Social Development personnel in Inuvik for creating conflict because we had called Yellowknife for some verification of policy. I might add that we are still waiting for some written statement of policy from the department on their responsibilities with regard to payment of medical services, transportation, and social services.

This example is perhaps minor, but it's typical. As important as the lack of liaison co-operation between these two levels of government, the Inuvik Hospital and the nursing station have no social workers, only a psychiatrist who visits them frequently, and a psychiatric nurse whose duties are divided with public health. Social Development is to provide the social services for patients and in many cases the medical patient is also involved with some of the services of Social Development. Liaison co-operation frequently does

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not happen, or it happens only grudgingly. The person is defined as a "medical problem" or a social development case on the side of Health and Welfare, instead of co-operatively working with the individuals and families involved.

The Gordon Friesen study recommends the transfer of all health and social services responsibilities to one government, the Territorial. Administratively this makes sense, except for the other recommendation or factor which that study cites -- the goal of

"Effective and responsible political institutions so that the northern residents have the means to regulate the quality of their lives."

This is certainly not the case now. Many times it appears that Yellowknife is further away than Ottawa. Native people will have no more effective control or influences over health services under the Territorial Government than under the federal, and if the pattern of consultation continues as it has this past year, there is reason to believe that their influence will even be less.

I'm not sure if this is a written policy statement or not, I couldn't locate it in the files; but according to our conversations with Health & Welfare officials, and a written communication from the Honourable Marc Lalonde, two conditions must be met before a transferral of health care to the Territorial Government was carried out. One is that

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the Territorial Government must demonstrate the ability to deliver the same or improved level of health care to the residents of the north, and the other is that prior consultation must take place with the Dene and Inuit people about this transfer.

Needless to say, I'm not an authority on the level of competence needed to deliver health care services, but if part of that competence is the involvement of native people in their own social and health care programs, the past track record of the Territorial Government is zero. Health and Welfare officials from Ottawa and Edmonton have talked with COPE over the past year about such a transfer, and Mr. Sam Raddi has reiterated his firm opposition to this. Conversations with senior officials of the Territorial Government, Social Development in particular, concerning this transfer have also been nil. So I understand from employees whom I know there that the policy goal of the government is to take over health care as soon as possible. I don't mean to imply that things are rosy with health and welfare, and I think my previous testimony has outlined some of the problem areas. But until the structure of the Territorial Government is changed so that native people have real mechanisms of influence and control, and transfer of health services to this government offers little hope in the improvement of services to native people.

If the regional plan MDDGAG,

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1 the workings of which COPE witnesses talked to you
2 about, are examples of the quality of planning and
3 assessment of pipeline impacts, as well as community
4 consultation, then we can expect real harm if such
5 a transfer takes place. But really whether it's
6 the Department of National Health & Welfare or the
7 Territorial Government, a serious question must be
8 raised about the meaning of consultation.

9
10 Certainly there has been
11 dialogue with National Health & Welfare and residents
12 of the Inuvik zone, including COPE, over this past
13 year, and it has been on a haphazard basis, and we have
14 yet to see any results following our meeting with
15 Mac Lalonde last year. Although there are certainly
16 expressed concerns by Health & Welfare for consultat-
17 tion and involvement of native people, we have to
18 question what this means and whether important issues
19 to people here such as the transfer of health services
20 to the Territorial Government, provision of alcohol
21 services, environmental health monitoring, and control
22 are being decided without their involvement at all.

23 I have mentioned to you
24 the stated concern about pipeline impacts and what
25 planning and preparation was being done in the brief
26 given to Minister Lalonde last year. We recieved
27 no answer on this, and Social Development personnel
28 involved with pipeline assessment dealing with social
29 and health services were also unaware of anything being
30 done by Health & Welfare. They tried to obtain

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information from Health & Welfare. It was only in an informal meeting with officials from Ottawa last March 25th with some residents of Inuvik and members of COPE that we learned that Health and Welfare was working on the impacts of the pipeline. They apparently had no knowledge of our interest in this, and our repeated request for information. Well, this can probably be explained by the normal difficulties of bureaucracies in relaying information up through the chains of command. The recent controversy over the closing of the T.B. ward of the Charles Camsell Hospital cannot be so easily dismissed. Camsell Hospital in Edmonton has been the centre for some time for the treatment of native patients from the western N.W.T. who have to be sent out for treatment. It has a staff who are familiar with the health problems of native people, and permits native people to be with others from the north. I have indicated to you, Mr. Berger, the Minister's statement in his letter to Mr. Raddi, February 3, 1976, to the effect:

"That there will be consultation with Indian, Eskimo representatives about any changes in the delivery of their health services."

At the end of December of last year and early in 1976 COPE was contacted unofficially by medical officers both within and without National Health & Welfare that a decision had been made to close the T.B. ward of the Charles Camsell Hospital but without consultation with either the native people

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- or the medical officers of that hospital. COPE,
2 as well as other native organizations, were sent
3 communiques by these same medical officers who felt
4 that this decision had serious implications for the
5 health care of northern native people. I would like
6 to read you a part of a letter sent to Minister Lalonde
7 by a group of physicians at Charles Camsell Hospital.
8 This is dated January 20, 1976.
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I have a copy of that letter
if you would wish to have a copy.

"There are strong cultural and traditional ties which the native people have always enjoyed at the Charles Camsell Hospital. The opening of a hospital to the Albertan residents a few years ago has not interfered with this. Indeed now everyone enjoys the advantages of an integrated hospital, but a sizeable native population remains. Many of these people do not speak English and their comfort is increased by being able to convert in their own language. Although we have had difficulty in obtaining all the interpreters necessary from time to time, it is usually possible for patients to communicate freely. By tradition, the medical staffs and nursing staff here are sensitive to the problems and needs of the native people.

Tuberculosis represents one of several areas of special concern to the medical staff at this hospital and is one of our most important communication links to the North. There are other medical problems which are in a sense special to the native population. These include chronic lung disease in children and adults, chronic ear and eye disease, nutritional problems, alcoholism, infections and many others. It is vitally important that there remain institutions

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2 and groups of physicians whose interests are
3 strongly oriented to the investigation and
4 alleviation of these conditions. Interaction
5 between the hospital and public health nurse
6 in as important aspect of this effort. If
7 patients are scattered widely for care for
8 no special reason, this task is more difficult,
9 if possible at all.

10
11 Many of the physicians at this hospital are
12 greatly troubled by many recent events here
13 which are negative in character and create
14 an atmosphere at variance with the positive
15 productive atmosphere which is needed. Physicians
16 recognize the need for economy but certain health
17 services must be provided and someone must pay
18 the cost. For example, there has been a closure
19 of beds in several areas without the commitment
20 of financial support to development and maintain
21 ambulatory and foster home services which will
22 be necessary to develop an alternative system.
23 We are concerned with the withdrawal of school
24 teachers by the Department of Indian Affairs
25 which lasted four months before being corrected
26 by a local non-government agency. '

27
28 There has been a reduction in the number of
29 paramedical staff which must be compensated
30 by increasing the load on the nursing staff.

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1 Most recently has been the unexpected decision
2 made in Ottawa that patients with tuberculosis
3 will no longer be treated in the Charles Camsell
4 Hospital. No medical representative from this
5 hospital attended the Ottawa meeting. This was
6 not discussed with our local medical staff, with
7 T. B. control officers at the working level who
8 are best informed about the problem or
9 organizations representing the native people in
10 the North.
11

12
13 I'm sure you will agree that no medical system
14 can function with such appalling communication
15 and it should not come as a surprise that there
16 is an increasing loss of morale among many
17 medical officers here who are concerned with the
18 health care of native people. Frankly, the
19 only interpretation we can place upon recent
20 events here is that the Federal Government is
21 preparing to abandon its responsibilities of the
22 health care of the native population insofar as
23 the Charles Camsell Hospital is concerned".

24 This letter is signed by
25 twelve medical officers at that hospital. I might
26 also add that other communiques were sent to us by
27 medical officers who felt that they would not be
28 listened to but that native organizations might,
29 feeling that native organizations had more political
30 clout.

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2 Sam Raddi wrote to Marc ,
3 LaLonde in January expressing concern that there'd
4 been no consultation concerning this action taken
5 with regard to Charles Camsell. Further, this would
6 seem to negate the Minister's earlier commitment to
7 such dialogue. The Minister's response to Mr. Raddi's
8 concern was, "this is purely an administrative
9 arrangement to reduce unnecessary expenditures of
10 funds", and it had nothing to do with the level of
11 health care or the delivery of health services.

12 One must view this concern
13 for consultation on the part of Health and Welfare
14 with some degree of scepticism given this response.
15 It appears that what is worthy of consultation with
16 native people will be decided entirely within govern-
17 ment circles and then conveyed to them, if it is
18 conveyed at all. The fact that even the medical
19 officers most involved with northern native health
20 problems were not consulted raises the suspicion
21 that native health is not a priority item in
22 government decision-making.

23 The implications of this
24 for dealing with the health problems of an increased
25 population in the Western Arctic with the pipeline,
26 while attending to the present inadequacies of health
27 care are not reassuring.

28 A final concern I wish to
29 express that is not included in Mr. Wenzel's report
30 is the provision of and adequacy of housing, water

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2 supply, sewerage and waste disposal. The 1973 and
3 1974 Reports on Health Conditions in the N. W. T.
4 and the Gordon Friesen study indicate inadequate
5 levels of sanitation now existing in the N. W. T.
6 with regard to current health problems.

7 I have tried to find docu-
8 mentation on present sanitation conditions in the
9 Western Arctic and what department of government
10 was responsible for monitoring the adequacy of these
11 conditions, as well as the assessment of pipeline
12 impacts upon these services. I have been unable to
13 find anything except that this is another area in
14 which responsibility seems confused. In the 1974
15 report on Health Conditions in the N. W. T. it is
16 stated that, "the general supervision of public
17 health as it relates to sanitation, quarantine of
18 communicable disease, water supplies, school sanitation,
19 et cetera is handled in all zones by Environmental
20 Health Officers", and where health hazards exist,
21 these same officers have, "powers of inspection
22 relative to these hazards and powers of authority to
23 require that health hazards be abated".

24 There is such a position
25 for an environmental health officer in the Inuvik
26 Zone but it has remained unfulfilled for some time now.
27 That's no longer true. There are now two environ-
28 mental health officers in the Inuvik Zone.

29 THE COMMISSIONER: Is that
30 a function they are now carrying out?

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2 A I have a hard time really
3 saying that. I think you'd really need to talk to the
4 officials in the hospital in terms of what actually
5 they're involved in doing. I really don't have the
6 knowledge to tell you about that.

7 Q All right.

8 A When I wrote Health
9 and Welfare inquiring what documentation was
10 available on sanitary conditions in the Western
11 Arctic I was told the Department had only limited
12 responsibility over such matters that apparently goes
13 further than that of monitoring the safety of
14 water. I was referred to various other departments
15 of government including Indian Affairs, The Department
16 of the Environment and the Government of the N. W. T.
17 Whether any of these agencies are looking at the
18 present conditions of environmental health and the
19 adequacy of existing services in terms of the
20 population increases that could be expected with the
21 pipeline construction was not answered.

22 It seems indeed strange that
23 a department whose own officers acknowledge the
24 importance of poor sanitary conditions upon northern
25 native health is doing nothing to measure these
26 conditions and make recommendations to the appropriate
27 agencies of government responsible for the provision
28 of these services. Now, they may be. We just haven't
29 been able to obtain information with regard to this.

30 In closing, Mr. Berger,

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4 I hope your Inquiry will take seriously the concerns
3 and recommendations expressed in George Wenzel's
4 report. There is reason to believe, from the Alaskan
3 experience, the impacts upon health and mental health
6 of northern residents will be great with the
7 construction of a Mackenzie Valley Pipeline while the
3 adequacy of present health and mental health services
9 to meet such impacts must be seriously questioned.

10 Thank you.

11 THE COMMISSIONER: Thank you.

12 MR. BAYLY: Mr. Commissioner,

13 I would propose, if you are agreeable, to present
14 the evidence of the two remaining witnesses on this
15 panel after lunch.

16 THE COMMISSIONER: Okay.

17 MR. BAYLY: I wonder, sir,
18 if we could break to the regular time as it will be
19 a full day, even if we do start at two o'clock.

20 THE COMMISSIONER: All right.

21 We'll adjourn to two then.

22 (PROCEEDINGS ADJOURNED UNTIL 2:00 P.M.)
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(PROCEEDINGS RESUMED PURSUANT TO ADJOURNMENT)

MR. BAYLY: We're prepared to begin with the presentation of Dr. Hildes at this point, if you will read your submission to the Inquiry, please.

WITNESS HILDES: Mr. Commissioner, I have organized my remarks along the following lines: Some notes on the health of Inuit as I see it at the present day; secondly some --

THE COMMISSIONER: Could you just move the microphone a little closer to you? Maybe you could increase the volume. We're still kind of settling down here.

A Sorry.

Q We'll just pull ourselves together. I think we're ready now.

A O.K. I'll start again, sir, that I have organized my remarks on the following lines: First some notes on the health of Inuit, as I see it today; two, some expectations for change in health with industrial development such as a pipeline building; and thirdly, some notes on health care delivery system in the Northwest Territories, its strength and weaknesses, including some possible limiting factors to increasing demands; and finally some comments on community involvement in the health care system.

My comments on health and diseases of Inuit are brief, since many of these

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2 things have already been commented on and more fully
3 than I have, and some of them are in a draft paper
4 which has been submitted for publication under the
5 joint authorship of Dr. Schaefer, Dr. Sayed
6 and myself entitled:

7 "The Health Profile of Igloolik Inuit,"
8 which has been submitted as an exhibit.

9 I will say nothing about the
10 remarkable deterioration in dental health, which Dr.
11 Mayhall covered very completely this morning, and
12 again I will say very little about the remarkable
13 increase in myopia or short-sightedness in the current
14 generation of juveniles and young adults which has
15 been documented by a number of investigators and which
16 I'm sure Dr. Cass will adequately cover, and do it
17 much better than I can.

18 I should say, though, that
19 unless there's still some uncertainty about the nature
20 or the causes behind this change, which is a recent
21 change, and it probably is associated with some
22 changes in lifestyle such as schooling or diet or
23 both.

24 Dr. Schaefer has already
25 commented on the chronic middle ear disease in pre-
26 school and school-age children, and again although not
27 all the factors involved in the causation of this
condition are clearly established, certainly changes
in infant feeding patterns appear to be at least one
major factor since, as he has shown this morning, the

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2 condition is far less common in children who have been
3 breast-fed.

4 THE COMMISSIONER: Dr. Schaefer
5 discussed the lower incidence of some health problems
6 among children who were breast-fed. Is that again some-
7 thing that is not comparable to Southern Canada? In
8 other words in Southern Canada do you find the same
9 differences between the health of children who are
10 breast-fed and the health of children who are bottle-
11 fed, or do those differences only become alarming
12 among native families?

13 A I think it is a multi-
14 factorial condition in which it changes with time and
15 different populations, and certainly one does not find
16 the marked prevalence of chronic otitis media in
17 school children in Southern Canada who have not been
18 breast-fed as one finds in the Arctic; but when one
19 looks at the Arctic, and looks at Inuit children, and
20 Dr. Schaefer showed some evidence from a number of
21 settlements and he and I together have some independent
22 evidence from another major study which clearly distin-
23 guishes that.

24 Now I have an idea myself
25 which is hard to document that in some parts of
26 Southern Canada this condition was in the past much
27 more common, so that there are other environmental
28 factors other than infant feeding practices, but at
29 least when one looks at the thing statistically, one
30 can separate out infant feeding practices as one

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important thing, one important component.

I think the incidence of chronic otitis media in Southern Canada now is probably so low and the prevalence of prolonged breast feeding is so low that one could not distinguish in Southern Canada that particular difference. This, I think, studies of Inuit populations can sometimes demonstrate for us certain factors which turn up there which are likely to have played a part in the past in other societies which are no longer available for study. But the answer to your question, I think, if I understand you rightly, sir, is that there are lots of kids in Southern Canada that are bottle-fed who do not have otitis media. But within the Eskimo population as we have seen them within the last five years, this distinction is clearly drawn.

THE COMMISSIONER: Yes.

A Tuberculosis has been the scourge of Indians and Inuit, is now under much better control after years of persistent efforts and introduction of better treatment methods by medical services.

However, we must still maintain a strict surveillance of this disease since it is still more a problem in native people than in the rest of Canada, and I might add at this point, Mr. Commissioner, that something that I thought Dr. Schaefer might have referred to this morning in that there are some racial differences between peoples that do have an impact on

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disease, and he has, with other colleagues, published papers on the fact that a high percentage of Inuit metabolize anti-tuberculosis drugs much faster than Caucasians do, and therefore the treatment of tuberculosis with those drugs has to be especially monitored in Inuit people. This is tangential to some of the remarks made yesterday about alcohol and whether there was a racial basis for alcoholism. That's another problem, but certainly in some diseases there are racial distinctions such as Dr. Mayhall mentioned this morning, that are important.

Chronic obstructive lung disease commonly referred to as chronic bronchitis and emphysema is a very important disease of middle age and older adults, particularly men and Inuit. Again, we must admit that we do not know the relative importance of all the underlying causitive factors, and in this case it seems likely that urbanization and diet may not be important causitive factors. In fact, Dr. Schaefer has published papers in which he has expressed the opinion that men who spend more time -- who spent more time as traditional hunters with dog teams are particularly prone and therefore the implication of exercise in very cold air may be a factor.

However, there is very little doubt that the very heavy cigarette smoking which now characterizes Inuit society is an extremely important contributing factor in this disease. This condition

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2 has also important secondary consequences on the heart
3 and it is probably the most common cause of heart
4 failure in Inuit adults at the present time, in very
5 distinct contra-distinction to the common cause of
6 heart disease in our society which is coronary
7 artery disease.

8 With regard to cancer,
9 a recent review conducted by -- published under the
10 authorship of Dr. Cameron and McGill, Dr. Mead, a
11 colleague of mine, and Dr. Schaefer and myself, shows
12 cancer to be an increasingly important disease in
13 Inuit, particularly cancer of the lung where both
14 men and women are now affected and affected to a
15 greater extent than in Canada as a whole, particularly
16 Inuit women.

17 Also there appears to be a
18 very sharp increase in uterine cervical cancer,
19 cancer of the womb, in Inuit women. There is very
20 little question in our minds that these changes indi-
21 cate some factors, some environmental factors which
22 are causing these important changes in disease
23 pattern.

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25 (QUALIFICATIONS AND EVIDENCE OF JOHN T. MAYHALL MARKED
26 EXHIBIT 764)

27 (EVIDENCE OF GAILE NOBLE, MARKED AS EXHIBIT 765)
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2 In addition the previously
3 recognized special high incidence of cancer of the
4 salivary gland, nasopharyngeal cancer and to a lesser
5 extent kidney cancers which we have known for years
6 to be more prevalent in Inuit society.

7 Acute infections continue
8 to be important diseases, particularly in infants
9 and children, not only infections of the respiratory
10 tract where the prevalence and severity of viral
11 disease makes some of us wonder about some racial
12 immunological defect, but also common infections
13 such as gastroenteritis, meningitis, septic arthritis
14 and infections of the bones and infections of the
15 genito urinary tract are particularly prone and the
16 latter in females.

17 This we coined a term called
18 infection pressure on the population is associated
19 by some people with poor housing, poor hygiene, poor
20 water supply and unsafe waste disposal. These are
21 certainly conditions which have become more pressing
22 with urbanization and which are still remarkably
23 unsatisfactory in most communities of at least the
24 central Arctic.

25 High infant mortality and
26 morbidity which Dr. Schaefer mentioned this morning
27 continue to be features of native health. I will say
28 very little about this because he has already referred
29 to the study being carried out by his department on
30 longitudinal study of infant morbidity and mortality

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and particularly the relationship to social situations and high fertility.

Trauma, alcoholism, V. D., behavioural disorders which took up yesterday's session draw attention to major effects on health of the social upheavals caused by cultural change and I don't propose at this point to say very much or anything more about these major disturbances that have been covered yesterday and also mentioned very eloquently by Dr. Schaefer this morning.

I would, however sir, like to comment on some of the conditions which are absent in Inuit society as we see it today and I refer particularly to obesity, hypertension, diabetes which have become features of Canadian Indian populations and which may, in fact, be in store for all Inuits unless some preventative action can be instituted. Arteriosclerosis, this is another diseased condition which Dr. Schaefer referred to this morning under the title of calcification of arteries which is far less common in adult Inuit than in the rest of Canada.

We might refer here too to physical fitness and muscularity which are likely to change remarkably with increasing urbanization. So, life style seems to be particularly important regarding--particularly I guess with regard to diet and physical activity which has relevance to these diseases of civilization as we often think of them.

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2 I should also comment on the
3 relatively improved position with infectious skin
4 disease such as impetigo, scabies and lice which have
5 been considerably improved in the Arctic over the
6 past fifteen or twenty years and which I think one
7 can attribute largely to the efforts of the nurse
8 practioners of Health and Welfare who not only treat
9 cases early but also through their efforts and public
10 health and in health education of influencing personal
11 hygiene, school health programs, maternal and child
12 care, et cetera.

13 If I can turn now, sir, to
14 what one expects in terms of disease patterns and
15 prevalence rates with accelerated changes associated
16 with industrial construction. The following comments
17 are my personal opinions. They may be controversial
18 but they are my opinions based on my experience and
19 understanding of health matters in the Arctic.

20 First I expect a worst thing
21 in mental health status of people in communities which
22 bear the brunt of the influx of southern workers and
23 money. I'm going over old ground again. As part of
24 this there'll be increased hostility, alcoholism,
25 V. D., trauma and the increase in trauma will be
26 of both the accidental and deliberate kind, including
27 such conditions as child abuse, gunshot wounds, frost
28 bite and those sort of things.

29 Now, I'm specially qualified
30 in mental health or psychiatry but I, therefore, offer

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the following comments rather tentatively to elaborate on this opinion. I think that the cultural change to which the indigenous people are subjected are not simply changes towards integration or fusion with the larger Canadian culture.

The indigenous peoples have already had to adjust to urbanization, wage earning, education, dietary change, et cetera, and there has been an evolving set of values which are obviously less homogeneous than the aboriginal culture but the point I'm trying to make, sir, that their new sets of values will still remain distinct from the simultaneously evolving cultures of non-natives who are adapting to the North.

These will also be non-homogeneous. For example, the adaptation of construction crews is almost certainly different to the North than that of school teachers or administrators, so that my point is that the new adaptive culture of the Inuit will still remain distinct from the adapting culture of the people who move into the North and I can't predict the results of these matters with any precision but I have no doubt in my mind that mental health and related matters will loom even larger as important health concerns in the future.

Secondly, I do not expect a decrease in the conditions that directly or indirectly are affected by crowding, poor housing, unsafe water supply and an adequate waste disposal; since in my view

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2 it is unlikely that these expensive features of
3 urbanization will keep pace with the influx of new
4 people during industrial construction.

5 Thirdly, the changes in
6 habits, such as smoking, which I eluded to in terms
7 of chronic obstructive lung disease and cancer of the
8 lungs, the changes in those habits which are required
9 to significantly change the statistics, health
10 statistics, are so difficult to achieve and require
11 a degree of sophistication which does not automatically
12 follow affluence, that I can see little hope for
13 immediate improvement in these areas.

14 Now, as an aside, Dr.
15 Schaefer told me privately in conversation yesterday
16 that there is now a trend of decreasing use of
17 tobacco in teenagers. That I think is happening in
18 our southern society too but nonetheless, the influence,
19 the effects of that will take a long time to change
20 the picture of lung cancer and chronic obstructive
21 lung disease in the Eskimo society.

22 If I may turn now, sir, to
23 some comments on health care delivery; I wish to
24 make reference--I'm no expert in the area but a
25 discussion which Dr. Jean Briggs of Memorial
26 University in Newfoundland made in contribution to
27 the 1975 Churchill Health Conference which I'm
28 submitting as an exhibit, the proceedings of that
29 conference and a very brief quote. "There is much
30 greater similarity in the way physical and mental

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illness are conceptualized in Inuit thought than our thoughts".

In other words, Dr. Briggs is telling us that even at the present day, that the concept of health and disease in Inuit is still very different from ours. Nonetheless, we must all be clear that the present health care system in the Northwest Territories is one which has evolved and is operated bureaucratically by the Federal Government.

Now, to comment a little bit on the current system of health care delivery, I have set that out in some detail in a manuscript of a paper in press at the present time which I am also-- which I've also submitted as an exhibit called "Health Care Delivery in Labrador and Northwest Territories", which evolved out of my studies undertaken at the request of the Royal Commission on Labrador.

(PRESENTATION ON HEALTH CARE, INUVIK REGION - JANUARY 21, 1975, COPE MARKED EXHIBIT 766)

(RESIDENTS PERCEPTIONS OF HEALTH DELIVERY SYSTEMS IN SIX SETTLEMENTS BY GEORGE WENZEL MARKED EXHIBIT 767)

(LETTER OF JANUARY 20, 1976 TO HONOURABLE MARC LALONDE FROM PHYSICIANS AT CHARLES CAMSELL MARKED EXHIBIT 768)

(QUALIFICATIONS AND EVIDENCE OF DR. J. A. HILDES MARKED EXHIBIT 769)

(HEALTH OF INUIT OF NORTHERN FOXE BASIN BY HILDES, SCHAEFER, ELLESTAD-SAYED MARKED EXHIBIT 770-A)

1 (UNIVERSITY OF MANITOBA MEDICAL JOURNAL, 1975,
2 CHURCHILL HEALTH CONFERENCE MARKED EXHIBIT 770-B)
3 (HEALTH CARE DELIVERY IN LABRADOR COMPARED WITH
4 N. W. T. - J. A. HILDES MARKED EXHIBIT 770-C)
5 (HEALTH CARE IN NORTHERN QUEBEC - B. STEWART,
6 MCGILL MEDICAL JOURNAL, P.P. 30-37 MARKED EXHIBIT
7 770-D)
8 (QUALIFICATIONS AND EVIDENCE - DR. E. CASS MARKED
9 EXHIBIT 771)
10 (TRANSPARENCIES IN SUPPORT OF DR. CASS'S EVIDENCE
11 MARKED EXHIBIT 772)
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I will just briefly refer to that general system of health care delivery which pertains in most parts of the Northwest Territories, there are some exceptions particularly in Yellowknife and in Hay River but I think the parts that will be affected principally by pipeline development still have the same system which I will allude to briefly.

That is the primary care in small settlements as provided by nurse practitioners in nursing stations in those communities, and these nursing stations are operated by medical services, health and welfare Canada.

The second level of care is constituted by local hospitals such as Inuvik, Yellowknife, and the Western Arctic, and Frobisher Bay, and in the central Arctic by the Churchill Health Centre.

The third level of care or base hospital facilities are located all outside the Northwest Territories at the present time in Edmonton, Winnipeg, Montreal.

Now, connecting these three levels of care one has a system of visiting physicians usually from the secondary level to the nursing station, and one has a system of visiting consultants from the third level, that is the base hospital level, to the secondary level, the local hospital, and sometimes to the nursing station itself.

Then there is a communication

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net

which is usually be telephone, but in some areas it is still reliance on radio-telephone, and of course the system is connected by a transportation net which is usually a commercial carrier, scheduled flights or charter.

Finally there is an administrative agency, in this case medical services, which operates the entire system either directly or under contract with other arrangements such as Yellowknife physicians, Edmonton consultants, the University of Manitoba in my own case. ^{Administrators} Medical Services control the involvement of these other agencies in their provision of their services into that system.

This sytem was put into operation in the Northwest Territories with the formation of the Northwest Territories region of Health & Welfare about ten years ago, and there has since then been gradual development across the Northwest Territories until now I think I'm right in saying all the centres of population of 200 people and over have at least one nurse practitioner in a nursing station, and all nursing stations are visited usually on a fairly regular basis by general practitioners and to a varying extent in the different zones by consultants.

The training of nurse practitioners for their roles as the primary deliverers of health care has become more formalized, but perhaps the turnover of nurses is now faster than it used to be. There has been a tremendous improvement

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2 in telecommunication and in air transportation over
3 the last 15 years or so, and increasing improvement.

4 Now again I might comment
5 on this current system which I've outlined very
6 briefly, and again these are my personal opinions
7 and therefore may be controversial.

8 The involvement of native
9 health workers in the system has been slow and
10 hesitant, and limited to the lower level positions
11 such as maintenance people, interpreting, maid
12 services, nursing aides, nurses' aides, and community
13 health aides. Not that these are not important
14 services, but that's the level at which local people,
15 local health workers are currently involved.

16 There is a growing pressure
17 and criticism from communities over what seems to
18 be sometimes minor matters, such as the provision of
19 ambulance services in small communities, or the need
20 for a nurse on call to be always on duty, the demand
21 for services outside regular hours, sometimes often
22 for what appear to be not too urgent matters. There
23 is also -- one hears demands for resident physicians
24 and sometimes without appearing that there appears to
25 be a lack of recognition, that transportation and
26 communications have in my mind largely outmoded solo
27 practitioners who operate without hospital facilities,
28 and also without recognition of the difficulties
29 in costs of maintenance of good secondary care hospi-
30 tals, even with a minimum number of beds. I think

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sometimes that these realities have also been overlooked by medical services. But they are difficult matters to deal with because local people make demands and sometimes those demands may not be able to be met.

Thirdly, there appears to be resistance on the part of the bureaucracy to the involvement of local people in the operation of the system of health care. I think Health Advisory Committees are slowly being formed and persuaded to function, but as yet there is little or no involvement in management or policy.

Now, if I may, sir, quote from something I came across in a McGill Medical Journal, Volume 44, of the spring of 1976, in an article on "Health Care in Northern Quebec" which shows that this -- the opinions I've expressed here are not necessarily or the conditions are not necessarily confined to the Northwest Territories. This was a study undertaken on behalf of Quebec Indians by some people from McGill and under the heading of "Indian Involvement in Health Care Delivery", if I may read a paragraph:

"The right of Indian people to share decision-making does not stem solely from their aboriginal rights. It is the accepted right of any group to share in the decisions that affect them, and this principle has been accepted and applied on a broad scale in modern society. The

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community Health Centre project,"

Hasting Report, Ottawa 1972,

"and the Caston Gai Netvous Report of which Bill 75 is the legal expression in Quebec are just two proposals which elaborate the need for a substantive involvement of consumers in the health care system. The basic criterial of efficiency alone demands such involvement, as both logical and necessary. A system that is at least partially controlled by its users is bound to be more adapted to the needs of its patient population, and therefore more efficiently utilized.

I was prepared to discover that consumer participation on a remote Indian Reserve would not have attained the same level as that characteristic of the users of the urban community clan in which I had worked; it was still somewhat of a shock to learn that there is no way that an Indian dissatisfied by some aspect of the health care services can hope to influence the system. From the selection of the field nurses to the imposition of a heavy-handed dentist who treats school children without parental permission, Indians are powerless to intervene. "

That's the end of that quotation from this article in the McGill Medical Journal.

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MR. BAYLY: Dr. Hildes,
before you go on I wonder if you would just give the
name of the author again?

A Yes. This particular
paper is published under the name of "Health Care
in Northern Quebec" by Barbara Stewart, and the
article is based on the experience of the author while
she was a member of the consultant team that was
hired by the Indians of Quebec Association to evaluate
the health services of Quebec Indians, and the reference
is on page 30 to 37 of issue No. 2 and 3, spring of
1976.

Q Thanks very much.

A On the political and
cultural scene I think there are new bodies coming
into being which will likely come into conflict with
the bureaucratic operation of health services. Some
of these like COPE, I.T.C., and its regional associa-
tions and I.C.I., the Inuit Cultural Institute, also
local Community Councils, Regional Councils, and
Territorial Councils will become increasingly interested
in making the health care system more public.

The local and regional
participation should be encouraged and in my view should
progress through stages of educational, advisory,
policy involvement, with a view to local or regional
control within a matter of a few years, control of
budgets and policies with guidelines, standards, and
professional qualifications set and monitored as
necessary by government or professional organizations.

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Again, if I may make an aside and quote from experience which I can't document but it can be checked out that the Big Eddy Reserve in The Pas have made an arrangement with Manitoba Region of Medical Services that to hire their own nurse and they employ the nurse. This, I think, is a much more reasonable arrangement where there are constraints on both sides because the local community, having hired a nurse, is not about to be unduly critical because they would have to find another one if they were and on the other hand, the nurse then works directly for that community rather than for a third party.

If I may go on sir, to comment on the responsiveness of the current system to increase demands and I think again this is a matter which was touched on by Dr. Schaefer this morning. How would the present system respond to a relatively sudden and greatly enhanced demands of the major industrial development. A number of dangers should be recognized.

First, the nursing station and physician personnel are even now probably critically limited by recruitment problems and rapid turnover and that system I think would have difficulty or be unable to cope and unable to recruit sufficiently to cope with the extra load of construction. If the demand by health personnel by industry and highly paid workers and managerial staff is to be met, it may require that all new influx of people be

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2 accompanied by a realistic component of health workers
3 and in that case, it would be also important to ensure
4 that there were not--that the two parallel and
5 separate systems did not ignore each other but became
6 integrated.

7 Now, my comments on the
8 strategies for the future to meet increasing and
9 changing demands such as--including pipeline con-
10 struction, a number of actions are required.

11 First I think an integrated
12 plan for the projected needs sufficiently in advance
13 to recruit or train staff and to provide appropriate
14 physical facilities.

15 Secondly, the establishment
16 of local and regional advisory boards who have a
17 built-in timetable for revolving into an operational
18 role with control of budgets, personnel, policies
19 and programs within certain legal or desirable
20 guidelines. If I may expand on this, sir, with
21 quoting the example that I am very familiar with
22 of the Churchill Health Center which has evolved over
23 the past five years. When that new health center
24 was being planned, a community board of fifteen was
25 set up and that board now owns and operates the
26 center including the budgets and the program planning.

27 The members of that Board
28 include two members from the Churchill Band of
29 Registered Indians; two members from the local
30 Metis Federation; two members nominated by the

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Keewatin Inuit Association; one member elected by the employees of the center; I think it's five members who are nominated by the local government district of Churchill as citizen members and then there are only two members who are outside those categories. One is a member appointed by medical services, one member out of fifteen; and one member out of fifteen appointed by the university.

Now, that Board hires its own executive director and appoints its own medical advisor and from time to time, they may appoint outside consultants to satisfy themselves that their employees are doing a satisfactory job. Two such reviews by outside consultants are currently under way and will be reported to the Board of the Churchill Health Center very shortly.

One is a medical audit by the College of Physicians and Surgeons of Manitoba. Another is an independent audit of the whole function of the Churchill Health Center as viewed by Professor Vince Mathews, the head of the Department of Social Preventative Medicine of the University of Saskatchewan and who has nothing to do with either medical services or with the Churchill Health Center, so that he is an independent consultant.

I think there is, sir, also to move on an urgent need to recruit native people into the health care system at all levels, including health professionals. I recognize the great difficulties

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2 in this but I think that our society as a whole and
3 northern society particularly has not been moving
4 strongly enough in this direction.

5 I also mention the integration
6 of health and social services which have been mentioned
7 before. I'm not saying how that integration need
8 necessarily take place or whether they need be all
9 under one direction but certainly the health and
10 social services should be more closely integrated
11 than they are at the present time and as I see them
12 in the Keewatin.

13 A major defect of the current
14 system is the complete lack of an independent
15 professional audit. The Regional Director of Medical
16 Services appears to me to be the only authority
17 aside from an occasional ad hoc advisor of his own
18 choosing. I think it is highly desirable that
19 regular, independent, expert advisory committees
20 be established to advise both government administration
21 and to advise local or regional boards.

22 Now, there are a number of
23 sources for such expert help. This may be the
24 universities that have experience in this area. Their
25 independent and expert assessment could also be
26 provided from licensing bodies in certain provinces
27 that are moving in this area. Such independent and
28 expert assessment would then either provide assurance
29 of adequacy of service or would delineate deficiencies
30 and make recommendations for change.

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I'm strongly in favor of having the introduction of such a professional audit. If I may sum up, Mr. Commissioner, the present status of health appears to be in transition, caused by urbanization and other changes in life styles such as diet, physical activity and cultural values.

In spite of the development of a health care system and the increasing involvement of nurses and physicians, the social and other changes are imposing serious strains upon health and health care delivery which will be increased by pipeline construction due to increased demands by the influx of people and also due to accelerated social change.

I anticipate the increased utilization of health and social services particularly in the areas of mental health, alcohol and family services. It is recommended to accelerate the process of community and regional involvement in health care until local autonomy is achieved within certain governmental and professional guidelines. It is recommended that the involvement of native people as workers at all levels, including full health professionals be greatly accelerated through educational and promotional programs.

It is recommended to promote adult health education in home economics, nutrition, sanitation, and the care of minor illnesses. A program is needed to ensure adequate housing, water supply and sewage disposal for native people as well as for

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in-migrants in all communities and particularly in those where a projected large influx of people and money during construction appear to be imminent.

A system of ongoing, independent professional audit should be established whose reports would be available to local and regional boards as well as to government administration.

THE COMMISSIONER: Thank you, Dr. Hildes.

MR. BAYLY: Mr. Commissioner, could we now turn to Dr. Cass's paper and Dr. Cass, could you take your paper and present your evidence to the Commission.

THE COMMISSIONER: Excuse me, Dr. Cass, just before you begin. I'm just trying to absorb all the material we've had so far this morning. Dr. Schaefer, you showed some slides. Those slides are in your paper, aren't they?

MR. BAYLY: I think the only exceptions of those are the ones that are photographed. Is that correct sir?

WITNESS SCHAEFER: Yes, there are some slides which we added which we have not included although to some of them I alluded in my paper but some others I did not allude to but I had already expressed my agreement to copy those either in coloured prints or in slides, whatever is preferred by you sir and would submit them too and have asked for permission to present them.

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THE COMMISSIONER: Oh, fine.

A Do you
want coloured prints or do you want slides?

THE COMMISSIONER: Well,
slides are good enough. I don't know what's involved
in either but--

MR. BAYLY: Copies of those
slides could be made available and we could request
Dr. Schaefer to do that for the Commission.

THE COMMISSIONER: Fine.

A Yes, I
shall submit wherever tables are possible, just the
tables and most of those have ^{been} submitted but those
that were not submitted, will be submitted, and in the
other case, colour slides or wide coloured prints.
Thank you.

MR. BAYLY: I have with Dr.
Cass's presentation, sir, photocopies of the
transparencies that will be used off and on throughout
and I'll ensure that copies are submitted for the
record.

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I understand they have. Do
you have copies of those before you, sir?

THE COMMISSIONER: All right.
Dr. Cass, I have that.

MR. BAYLY: Some of them are
on long paper.

WITNESS CASS: Shall I start?

THE COMMISSIONER: Yes, please.

A Mr. Commissioner,
first of all before speaking to you, I'd like to
say how pleased I was that COPE trusted me sufficiently
to speak on this panel. I think also I've explained
probably why, although I'm a newcomer to Canada, I
do not suffer quite so much from cultural shock as
some people might have done. You see, I travelled
intensively working in Europe, North Africa,
South America, etc. I've had patients of mostly
all European countries, also Arabs, North Americans,
East Indians, South Americans. Three languages are
basic to me and no difficulty. Two more I could
speak moderately well, and I could examine my
patients in seven different European languages. I had
and still have friends and medical acquaintances all
over the world, and am lucky to be able to attain
the picture of any ocular disease in different
countries.

For many years I've realized
that the pattern and distribution of eye disease,
and for that matter, all diseases, differs all over

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the world, and they are determined by race, climate, work, homogeneity (that's inbreeding), heterogeneity (that's mixed blood), religion, diet, and tribal taboos.

I arrived in Canada only in Christmas '56 with no real knowledge of the Indian and Eskimo, except for the rather sort of romantic picture given in childish books by Femimore Cooper; and also had read Farley Mowatt, who had written "The People of the Deer." I also obtained some information from an Admiral Crewdson whom I met at a cocktail party. He was an American admiral in charge of the DEW Line and he told me about the importance of gaining control of the stratosphere. I arrived, I hope, with an open mind hoping to gain a knowledge of the character and mode of life and diseases of my patients. I had no fear nor distrust as I had found among some people of the Indians.

I am of British origin, a mixture of Scotch, Irish, French, and Dutch. My great-grandfather at the age of 17 was a medical student on an Arctic expedition with Sir James Ross in 1822, and in 1824 with the famous Captain Bligh on a ship called the "Brunswick". I have his journal or his diary of that voyage. On the other side of my family, a great-uncle, David Armstrong, who was the attorney-general in Quebec in the time of Queen Victoria. So you see, we have had connections with Canada for some time.

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Although I am of British origin and have many British friends, I cannot say I know the British; only my friends and my varied patients, and I cannot glibly say that I know any other nation by any other than this criteria. This includes the Indian and the Eskimo. I have, I know, friends amongst them with whom I feel at ease, as they do with me, they have taught me a lot of their languages and cultures, have helped me, ignored my unwitting mistakes and my lack of knowledge of their culture, and I am grateful.

They also saved me from further cultural shock. Some people find it harder to adapt to other cultures, but my background certainly helped. I recently returned from the Indian Ecumenical Congress where I met many friends, many Indians, old friends and new. I was asked by one from what reserve I came. I took this as a compliment. He had been introduced to me by another Ojibway. He felt completely at home with me and could talk to me as he could with his own people.

Furthermore, there is an observation I must make after what people have said about organizations this morning, that I was amazed at the immense organization of this congress. There were nearly 3,000 people. I don't know how many -- nobody knew how many were required to feed each day, but there was always enough food, and I remember one day when it was pouring with rain, the chief at Morley

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organized it so that within one hour, between five and 600 people who were going to the meetings that day were transferred from the ground to Morley Village itself, where we were housed in the arena. Not only that, lunch accompanied us that day and was excellent.

My first year in Canada I was sent to Moose Factory where I was fathered by an old Cree Indian who taught me the language, the customs, the country, the mode of life, and the legends of his people. He took me up the bay to Fort Albany in a Bombardier at 40 below and I had only been six weeks in the country. The rest of the year I was with the Ojibways, Ottawa, and the Hurons. I was sent to Aklavik in April of '58, the government having arranged for me to stay for three weeks. It seems to me it's been a rather long three weeks. Since then I have travelled extensively from Pelly Bay in the east to Old Crow in the west, and as far south as the Alberta border. In fact, I spent many years travelling over an area of about a quarter of a million square miles.

I had already learned from previous experience it is essential in order to give good medical treatment to be able to communicate with one's patients, not only in the silent language, but in their own language. All I could do here with six languages and about 16 dialects, was to learn sufficient to test eyes and to ask simple questions. I dislike

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2 having interpreters, especially when they are not
3 medically trained. Nothing is more exasperating when
4 you have asked something which cannot be answered by
5 "yes" or "no", and after a prolonged discourse, the
6 interpreter turns to you and says, "He says 'No.'" Or
7 the interpreter is bored and asks what he thinks and
8 not what you want.

9 Dr. Cuthand, last week -- or
10 it's a week or two ago now at Morley -- told us a
11 story about a nurse who had an interpreter. Instead
12 of saying to the old lady, "You will go to the hospital
13 and have two shots," he said, "You will go to the
14 hospital where you will be shot twice." My own
15 efforts often gave them a chance to laugh at the
16 doctor and to this day I've been so teased I don't
17 know in Slavey if I'm talking about snow or lice.
18 And I once told an astonished Cree, instead of saying
19 "Kitte wapita ne chas" I said "Kitte wapita ne chos" so I said instead
20 of "Look at my nose" I requested him to look at my ass."

21 In order to realize and
22 understand the basic principles guiding their lives
23 and therefore the pattern of disease, I have travelled
24 many times for a few days with our native people by
25 dog-team, box, Bombardier, etc. I have also been in
26 many native houses. I have even been lost on the
27 tundra. I have slept in Indian tents, crawled in and
28 out of igloos, and you would never refer to "the
29 lazy Indian" again if you had seen one young Loucheux
30 Indian who drove me in a dog-team just before breakup,

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up in the Arctic. We were on the Mackenzie on cracked ice, with water on both sides and no boat. We did 92 miles in 23 hours of which he ran most of the way. Loucheux are known for being long-distance runners.

Now these are the points I'd like to bring out. What does the pipeline imply to different groups of people? To the average Canadian it suggests simply a further supply of energy for the south. To the oil companies, a source of oil and gas, and an expansion of their business. To the economist, development of the natural resources of the land with the growth of agriculture, towns, and all the buildings it entails. But he must consider if the value of the natural resources justify the high expenditure, and if the resources are of scarce supply in the country (and the needs are so pressing) that the sources must be tapped for the good of the nation.

To the ecologist, it is a situation which must be carefully studied to see if the tapping of these resources will lead to the destruction of the land and the sea; and is it worth it? And also if there are oil spills, how can they be dealt with and how to prevent contamination with destruction of animal life and vegetation?

But far more than anything, what does it mean to the people who have inhabited the land for generations, and have depended on the natural resources of their land for their livelihood

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2 and security? Many of them still to this day supplement
3 their diet with the natural resources of the land,
4 which are far better than store food.
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2 I quite agree with everything
3 that Dr. Schaefer said this morning. Basic foods
4 such as fish, wild meat and birds, edible fruits and
5 plants are all available and still clothing such as
6 moccasins and parkas. Of course, they've had hard
7 times. At times they've starved and these supplies
8 may fail from time to time but this happens in every
9 walk of life and every culture. The fur from trapping
10 still brings them money for other necessities. Store
11 food is expensive. Wild meat and birds are far
12 better than the expensive store meat and wild meat
13 has far less fat. All this has been previously pointed
14 out to you and far better than I can do it by Dr.
15 Schaefer.

16 For example, the caribou
17 only gets fat on its back in the Autumn, and
18 traditionally, this was only given to the hunter.
19 Natural refrigeration can be used up here. You dig
20 up a square of turf down to the perma-frost and lay
21 your berries and your meat in containers and sacks
22 and this keeps them preserved. You can smoke or
23 dry your fish yourself.

24 The land is rich in edible
25 berries such as cranberries, blueberries, wild
26 strawberries, raspberries and rhubarb. I have even
27 seen wild gooseberries. They certainly have currants
28 of many kinds and also they have mint from which mint
29 tea can be made. They have spruce which supplies them
30 the spruce tea and Vitamin C. They even were kind

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2 enough to give it to the early explorers who were
3 suffering from scurvy. The natives knew that spruce
4 tea would cure and prevent this condition. They
5 also have plants, i.e., your dandelion leaves can be
6 used as a vegetable like spinach and they're rich
7 in iron. There are rose hip berries, again rich in
8 Vitamin C. There are even the juniper berries which
9 I discovered are used for abortion by the natives
10 in certain areas and which funnily enough in Britain,
11 "spirits of juniper" ie gin which used to be known
12 as mother's ruin. Of course, it was given by the old
13 wise women to cause abortion.

14 Firstly I want to give you
15 the general patterns of life. I should give the
16 native pattern first. If we're dealing with the
17 native pattern, they are, as Dr. Schaefer has already
18 pointed out to you, a close family unit with special
19 care being given to the children and the aged. They
20 have a lack of sense of time governed by the clock.
21 Time is governed by the necessity of the job, the
22 conditions of life. Knowledge of the country which
23 teaches them patience, acceptance of life and
24 inevitable events.

25 A lack of feeling of difference
26 between social structures in their own communities.
27 Hospitality extended to complete strangers irrespective
28 of whom they are. Politeness is considered to be not
29 asking questions.

30 Now, we deal with the whites.

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1
2 They are a far less closely knit family unit,
3 especially now. Children go to school, run their
4 own lives, old people are put in homes.

5 Work and meals are governed
6 by the clock. Lack of knowledge of natural
7 difficulties and impatience occurs when they come
8 into this country. They are much more conscious
9 of social strata. Unlike the Indians, hospitality
10 is usually limited due to social conditions or often
11 due to social and monetary problems; and they always
12 ask questions.

13 Now, when you get up here,
14 your actions, you must realize, cannot be governed
15 by the clock. You go on with your job until you've
16 finished. If you are living as a trapper or a hunter
17 there are no stores. You have to get your food and
18 you have to get your work done independent of the
19 clock. Personally I think it's a good idea. If I
20 want to finish a job of work, I go on until I've
21 finished it. I do not work scheduled hours and I
22 don't think many doctors do, and certainly the natives
23 cannot, nor can the farmer on the prairies.

24 I'd like to tell you a story
25 that illustrates this. There was a young priest who
26 came into Manitounin and he asked an old granny
27 to come at eleven o'clock in the morning to have a
28 christening as he had to go into town that afternoon.
29 and he said, are you sure you understand and she said
30 yes, father, and he made quite sure that she was going

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1
2 to come. Yes, eleven o'clock. And the old priest
3 said she may come. It won't be eleven o'clock. It
4 may not be twelve. It may be four o'clock in the
5 afternoon and the young priest said, oh no, she
6 understood perfectly well.

7 So, finally at four o'clock
8 in the afternoon the women did turn up with a baby
9 and the young priest was furious. He said, what's
10 the meaning of this? You'd promised you'd be here.
11 Why weren't you here? She looked at him fittingly
12 and said, no clock.

13 It is ironical to me to think
14 of the man who's rushing--he's working in the city,
15 who rushes to work, rushes for his meals, rushes home
16 and spends a year dictated by the clock, raising
17 his blood pressure by his efforts and shortening his
18 life, in order to save enough money to take his wife
19 and his family for a two week vacation to live in a
20 tent like an Indian.

21 With regard to politeness,
22 I remember a friend of mine coming from England who
23 was so struck with this. She said, "But these people
24 are so polite. They all say good morning to me. They
25 always open the door for me in the Hudson Bay".
26 Another example of a different kind of politeness, I
27 think, is this: recently in Morley where it was
28 pouring with rain, I came into my tepee, shared by
29 three young Indian men and one Indian women to find
30 one young man drying himself by the fire. I said to

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1 him, "John, I am sopping wet. I must change my
2 trousers." John politely turned his back and warmed
3 his hands.

4 With hospitality, well, I
5 wonder how many people would welcome two whites and a
6 strange Indian at two o'clock in the morning asking
7 no questions. I remember arriving at a Dog Rib tent
8 at the end of Marion Lake at 2:00 A. M. We were
9 tired, we were wet because of snow falling from the
10 trees where the dogs had hit them as they pulled
11 the sleigh. My guides went to find a place for me
12 to sleep. By the time I had arrived there was a fire
13 in the middle of the tent, and there were a number of
14 people in the tent who didn't know my from Adam;
15 no questions were asked, bag my sleeping bag which was
16 wet had been hung up to dry. My caribou rug had been
17 layed down for me between two young men and I was
18 made welcome, given tea and in the morning, poached
19 moose meat for breakfast. Still no questions asked.

20 Now, the whites in all good
21 faith come into this country and say you shouldn't
22 do it like that. You should do it like I do. I'll
23 show you. The natives sit polite and say nothing.
24 But I should be so pleased if someone knowing nothing
25 about my work, nor nordic conditions, came into my
26 office and said this to me. They wouldn't say it
27 again.

28 People do not realize, I
29 think, how climate, race, culture, diet, work,
30 religion, tribal taboos; all these things that were

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mentioned before, could effect eyesight and eye diseases; nor that the early signs of many general and neurological diseases are first seen in the eye. These also depend on the condition of life and the diet.

People do not realize that many defects in sight cannot just be cured by glasses and more and more we are finding these so-called defects, such as short sight, are often a disease which can be prevented and cured.

I will endeavor to show you how the changes in culture and the different diet and employment can affect your sight, and if your sight is impaired, it affects your whole mode of life. I want the diet patterns please.

Now, the original native pattern . The natural sources of food: plants, fruits, wild meat, birds and fish. The diet was low in salt, fat, carbohydrates and starch. High protein. Resulting in: longevity. The oldest Loucheux I saw was a hundred and fifteen. She'd been married in 1850. Low blood pressure, which at first appalled me; it was so low in the old people that I thought there was something wrong. Good eyesight. Lack of severe ocular diseases. High hemoglobin, that is there was no anemia. Blood calcium was high which is very important and there was low cholesterol because high cholesterol is associated with high blood pressure.

The white man's pattern was as

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follows: Store food, especially up here I'm referring to. Canned and frozen foods, cultivated fruits and vegetables, packed meat, artificially fed chickens, frozen fish, pop, candy. High salt, fat, carbohydrate, and starchy diet.

Resulting in: decreasing span of life, high blood pressure, heart disease, diabetes of the elderly, kidney disease, short sight, blinding ocular diseases due to the impaired circulation of the eye, cataracts, glaucoma, retinitis, et cetera. I will elaborate on those terms which I know are difficult.

Firstly, I want to talk to you about the problems of short sight and its increase all over the world. I do not--I have given at the end a list of references. I can let you have any of them and I have abstracts of translations from Russian, et cetera. This is a problem which occurs everywhere and we find that when people change their conditions of life, this condition arises, which I'll try and explain to you.

So, these problems are not only in Canada. As I say, I have the references beside my own statistics which can prove this to you. Short sight up here is serious to the people. Now, none of the older Indians nor Eskimo had short sight unless they had white blood in them. I can show you this from my statistics. These were the people born before the '40's. Because of this increase in short

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2 sight, there are now research centers in the States,
3 Japan, Australia, Russia and the United Kingdom where
4 ophthalmologists are engaged in extensive projects
5 to study the origin of this deformity and how to
6 prevent and correct it.

7 Formerly it was thought
8 simply that the eyeball was too long and this might
9 be racial or hereditary. More and more it is realized
10 that short sight is a disease which develops in a
11 child's life. With the object of combating this
12 menace, the International Myopia Research Foundation
13 was formed in New York and in 1964 the first
14 international congress was held. It gave interesting
15 and appalling revelations from research workers all
16 over the world. We now know there are many types
17 of short sight and many causes. Some show a
18 hereditary tendency. Others show congenital tendency.
19 Others are acquired.

20 What puzzled me at first
21 was I found that the children whom I'd given glasses
22 to and carefully tested them under drops, their
23 sight reverted to normal if they went and lived in
24 their own homes. This type of myopia which attacks
25 us here and which is attacking the whole world is
26 known as school myopia. Evidence has been found that
27 this occurs when people change their mode of life
28 and their diet. The length of the eyeball is the
29 same in these cases as it is with normal sighted people
30 and with some long sighted people.

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The length of the eye can be measured by ultra-sound and was measured in extensive research first done in Japan as long as 1939. The Japanese have now cut down their short sight by about 40% in the last few years.

This type of short sight is developing at a earlier age and also at a later age than formerly. We used to find that short sight started in children and this was older types, somewhere about the age of twelve. And after the age of fifteen you didn't get it starting. Now, it starts as early as six and as late as the twenties. Certain factors have been found when this condition starts, as I say, all over the world.

1. It occurs in people who have plenty to eat and are not starved, are often overweight, but whose diet is high in starch, carbohydrate, fat and salt.

2. Races on a high protein, low carbohydrate, low starch, fat and salt diet do not have this myopia.

3. Controlled experiments reveal blood calcium is lower than normal and here hemoglobin is often below normal.

4. It occurs more in urban than rural areas except where the soil is deficient in certain minerals such as calcium and manganese.

This change up here from native diet occurs when the children went to residential

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2 schools or when they moved to live permanently in
3 settlements. Now, their parents who've been brought
4 up on a high protein, low carbohydrate diet, et cetera,
5 did not get this type of myopia.

6 This again has been observed
7 in the people of the races studied by those research
8 centers. It has also been revealed by controlled
9 experiments that the blood calcium is lower, as Dr.
10 Schaefer found it, in the children who lived in
11 residential schools and in areas in the towns as was the
12 hemoglobin lower. This was also true for the children
13 in communities who were living on white man's
14 diet. Hemoglobin and calcium is lower when they
15 make this change and the blood pressure and the blood
16 cholesterol tends to go up in the older people.

17 The Russians have found
18 another interesting fact. In areas where there is
19 deficient calcium in the soil, there is also an
20 increase in myopia. The Russians are curing this
21 myopia not with glasses, but by, in early stages,
22 giving drops to the eye and by controlling diet.

23 There was another interesting
24 thing. A man came to see me the other day with this
25 type of myopia. It was quite low and I always question
26 them and ask the family history and neither of his
27 parents had had myopia. So, I then inquired. I told
28 him this about the Russians and the soil and his
29 family had come from another province and were
30 farming in South Alberta and he said to me in amazement

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1
2 that we have no calcium in the soil. We always have
3 to put it in and he was the first one, the eldest
4 one of his family when they first started. He was
5 born there when they came there and they hadn't found
6 out about the soil and he had this myopia.
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For races such as our Indians and Eskimos, now, myopia is a serious problem. You cannot wear any corrective glasses in extreme cold, especially thick myopic ones. Also there is another problem. It has recently been discovered that this type of what appears to be a simple myopia, in later life is associated with a blinding disease in other races that the Indians and Eskimos never used to get. It's too early to say now, but we may find it in them later. It does not give you any acute pain, but there is a gradual diminution of vision. There are papers out on this, and I have one recently by Professor Perkins from London, and this is the condition which the doctors will know is open angle glaucoma. We can, therefore, see that diet is of immense importance. In other words, the evidence from all over the world shows that a diet such as the natives use is far healthier than the average white diet, especially in the north where we have to rely so much on store food.

Now it was thought by some that the children were doing close work for the first time and this would cause myopia, but there is no evidence of this. This has been investigated, not just by myself, but by other people.

Contrary to common belief, extremely close, fine, fatiguing work is performed by all people who are living in the more primitive conditions, and this work would be done up here in

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1
2 dark winter months under appalling light'. Even to this
3 day I've seen in igloos and tents women and girls
4 sewing skins with meticulous small stitches or doing
5 intricate bead work with patterns, and making their
6 mocassins and parkas. The boys and men are mending
7 the nets and the mesh of snowshoes and dog harnesses,
8 and often the Eskimos are carving small figures. No
9 pure-blooded Indian or Eskimo prior to those born in
10 the '40s that I have seen had myopia. But when they
11 changed over and lived the life of the white, the
12 lighting in the houses improved, the lighting in all
13 government schools in the north is excellent electric
14 light.

15 I will now show you my
16 statistics. Can we have the first one, the myopia one?

17 I tried to take it from the
18 same area, there are certain factors that come in
19 with the whites because you didn't get up in the
20 far north, especially in the early days you didn't
21 get people with high myopia. Now you can see the
22 difference between 1958 and 1970. The whites already,
23 it was higher. The adults up there, though they were
24 healthy people, there were 16.7% with myopia and the
25 children, 9.2, pre-schoolers there were none. However,
26 when we got to the '70s you see although it hasn't
27 increased so much in the adults, again you have to
28 think of the work people are doing and I've taken it
29 from the same areas I've taken these Indian and
30 Eskimo, and the children, it had gone up quite

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1 appreciably and it was now present in pre-schoolers.
2 In the Metis, we find already there was some myopia
3 amongst the adults. There was less. There was a higher
4 degree in the children, none in the pre-schoolers.
5 Again it had increased from 2.8% in the adults to
6 21.04% in 1970, and in the children from 5.5% to
7 21.6%. There was none still in the pre-schoolers.

8 The Indians, the total refrac-
9 tions, there was 1.89, there was one Indian woman, she
10 was the daughter of the store-keeper who had myopia,
11 was born in '39, and that's why it brings it up; but
12 the total refractions were 1.89, among the children
13 2.92, and by '70 it had increased in the adults to 6.66,
14 school children 13.5, and in the pre-schoolers there
15 was none. The same with the pre-school Eskimos there
16 was none. But it had gone from 1.9% in the Eskimo
17 adults to 10.1% and in the children from 1.8 to 20.78.

18 Now when I take it in decades
19 we find that in those born before the '40s, you see that
20 in the adult whites, 26.0, in the Metis 19, in the
21 Indian 0.1. This was this one case of the Indian at
22 Old Crow, the daughter of the store-keeper, and in the
23 Eskimo there was none. Now in those born '40s and
24 '50s, you can see for yourself from this chart, I
25 hope you can see it at the back, that it has gone up
26 again considerably and it is now, you can see those
27 born in the '60s and '70s, these were statistics taken
28 in '71, and that again the percentage has gone up.
29 They were getting it among the younger, and it has
30 increased considerably amongst the school children.

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THE COMMISSIONER: Maybe
I'm missing that.

A Can I explain? You
see, the whites already, some of them had hereditary
myopia.

Q Yes.

A So they would have a
higher percentage; but even with the whites now, in
the white children it has gone up a considerable
percentage because of this so-called school myopia,
this particular type of myopia.

Q Well, for instance,
Indians born before 1940, there was virtually --

A There was only one
case in the whole lot of those where the numbers I
showed before in that particular statistic, there was
656 Indians and out of that, 556 Indians, the 0.1,
I think it worked out, I know there was only this one
child. I can show it to you, I've got a breakdown.

Q Well, what I'm -- I
must have missed something here, but the people born
between 1960 and 1970 --

A Well, they'd be younger
children. That's why we said we usually used to get it
at the age of 12, reporting at the age of 12, so it
appears in the age of the school children. Some of
those were pre-schoolers, and in the pre-schoolers
we didn't get it among the Indian and Eskimo. We are
getting it now.

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Now if I can have the next one small isolated settlement. You see where they were isolated, the Indian settlements were isolated, can you hear if I don't speak into the dictaphone? It's so difficult for this. Can you hear me?

Q I think you have to speak into it.

A Can you hear what I'm saying or not?

Q Well, for the recorders.

A Oh, right, I'm sorry. Now, if we take the small isolated Indian settlements where they're living much more on their own diet, some of the children have gone to school but not all of them, we find the percentage amongst the children born in '40s and '50s is less than it is in the semi-acculturated areas. It has gone up and in one area which was Arctic Red, nearly all the school children when I last took these statistics were going to residential school. Now you'll notice it's 20% there and it's gone up to 14% at Good Hope, and 15.5 in Old Crow.

Now when we get to the semi- -- I know it's difficult to show these statistics -- when you get to Old Crow, I mean when you get to the delta Eskimo and the Loucheux Indians, who were what I call semi-acculturated, they were having much more mixture of store diet, a higher percentage of store diet than the people in the small settlements, when

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2 we get to the delta Eskimo you see that the number
3 born before 1940, there was nobody with myopia, but
4 of the number of children born in 1940 and 1950 that
5 I examined, children seen with myopia were 22.19%.
6 When I got to the Loucheux Indians --

7 MR. SCOTT: Dr. Cass, can you
8 hang on a moment? I think Miss Noble has got the wrong
9 chart up and --

10 THE COMMISSIONER: Excuse me,
11 Dr. Cass . Maybe it would be convenient to you if we
12 took a five-minute break and stretched our legs and
13 then we'll --

14 A I think so because
15 these --

16 MR. SCOTT: Miss Noble is not
17 up to this.

18 A What?

19 MR. SCOTT: Miss Noble is not
20 up to this. You'll have to give her a hand.

21 A Im sorry, Miss Noble.
22 You've done wonderfully up to now.

23 THE COMMISSIONER: We'll stop
24 for a moment then.

25 A Yes.

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(PROCEEDINGS RESUMED PURSUANT TO ADJOURNMENT)

MR. BAYLY : Dr. Cass, if
we could continue, and perhaps before we do if I could
ask you about a slide you showed earlier.

WITNESS CASS: Yes, well I have
explained that to the Commissioner.

Q All right.

A The thing is this. I
did say at one stage ^{/that} formerly short-sightedness did
not appear before the age of 12. Well now that was
taken, the children born between the '60s and '70s,
those statistics were taken in the year '70 so those
statistics show children all below the age of 10.

Q Thank you. If we could
continue then with the next slide in the order of
presentation?

A Well, this was to show
within the semi-aculturated groups, that is the
delta Eskimo who were living around the Inuvik area,
and the Loucheux Indians again living around that
area, the percentage, of the children seen with myopia
the percentage was 22.19 among the delta Eskimo and
21.7 in the Loucheux. Now the ones, the children who
were born in the '60s you see now, originally we
didn't have it in young children, but those children
below the age of 10 were beginning to get myopia. Is
that clear? Now when we got to Old Crow, now
Old Crow was a particularly healthy lot of people and
they didn't have much white invasion until you got to

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2 about 68 when they got the airport, and the number with myopia, there
3 was one adult when I went in '58. She was the child of
4 the local store-keeper, which is significant. When I
5 got there in 1970, that one adult was still the same,
6 the daughter of the local store-keeper, and three of
7 those four children were other daughters of his.

8 Can I have the next slide,
9 please? Yes, Fort Good Hope you'll find again the
10 percentage there in 1958, there was some myopia among
11 the adults and there was in the school children it
12 was very low. It has increased in 1970 but not nearly
13 as much as in the semi-acculturated areas.

14 All right, well now when we
15 get out to Pelly Bay and Spence Bay, I got a shock
16 at Pelly Bay. But Spence Bay, as you see the number
17 with myopia was low, the percentage with myopia was
18 3.4 amongst the children born in the '40s and '50s,
19 previously in the people, both the Eskimo born before
20 the '40s there was no myopia; but when I got down to
21 Pelly Bay the first time I was appalled by the high
22 percentage of myopia. I then found it occurred in
23 all the children who had gone to residential school,
24 with the exception of one child who was again the
25 daughter of the local store-keeper. The mother was
26 a widow and this one child was staying at home and
27 her mother had to rely on the store food.

28 May I have the next one,
29 please? This is Pelly Bay with a split-down in
30 decades. Now when I went back in '70, I'd been there

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first in '68 and I went again in '70. ' Apparently the myopia was less, but as I went in the Easter holidays, the children did not come home for Easter, and they'd all gone to Inuvik and of those children all the children who were in Inuvik had myopia, so the increase had gone up to 26% not 0.9.

Tuktoyaktuk, when I went there last in '70, I think there was one pure-blooded Eskimo only left, he is now dead. The others were mixture, and you notice again they start with some myopia in '58 and it has increased considerably by 1970. The children go to residential school, first of all in Aklavik, then Inuvik, and they had been getting much more store food than they used to.

When it comes to a place like Akaitcho Hall, I did statistics there, and most of the children who went to Akaitcho Hall, even in '60, were children who spent most of their lives in residential schools. They were the brightest students, but often their myopia which they'd acquired early prevented them from taking certain occupations. You can't go out and be a hunter if you can't see, and a lot of them -- they were the good students and they went to Akaitcho Hall and you see the difference between 1960 and 1968. The Eskimo had increased from 16.1% to 60%. The Indians from 13.3 to 60.8. The Metis from 34.0 to 3.9, and you see the whites were higher to start with, again they had the increase.

Oh yes, we then found another

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1
2 thing. The girl children had a higher percentage
3 of myopia than the boys, and this I found when I
4 went into the schools. The boys quite often became
5 dropouts at the age of 12, they left school, they went
6 out to join their parents; and the girls had far more
7 years of school than the boys.

8 Other diseases associated
9 with diet, when I first went north I was struck by the
10 fact of the low blood pressure and high hemoglobin of
11 the old Indian and Eskimo people. This is page 19, Mr.
12 Commissioner. There was also a lack of disease which
13 is common in white people, which you all know, and
14 that is cataracts. The Eskimo in those days, there were
15 very few when I first went in '58, over the age of
16 60, and I thought at first it was an age factor.
17 Tuberculosis seemed to have had much more effect on
18 their span of life than it had on the Loucheux Indians.
19 The Loucheux live to well over 100. The oldest
20 Loucheux I ever saw was married in 1850 and there were
21 records of this, and we reckon that their age must have
22 been at least 115. The Hare Indians were in their
23 70's-80's, and again the ordinary cataract which we
24 find in white people was not present.

25 During a meeting of a society
26 of mine, the International Society of Geographical
27 Opthalmologists, it was mentioned the high percentage
28 of cataracts amongst the Indians of India. While our
29 Indians and Eskimos live their way of life, trapping-
30 hunting, etc., and on their particular diet, the diet

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of the Indians of North India was entirely different. Their diet, which was brought out by the doctor speaking on this, or doctors, their diet was rich in carbohydrates and starch, they had little protein. They lived sedentary lives and cataracts were so common they were setting camps up all over India and they still are, to operate on the Indians in their own habitat and to try and give them back some sight.

I found as I went further south amongst the Metis and Indians, cataracts became more common. The diet of the people living in the larger settlements, such as Hay River, Yellowknife, and Fort Smith, was much more the diet of the white. So you can see when you change to this inadequate diet you do get a number of diseases and this is going to happen more and more unless something is done about it.

We also find among the southern Indians, and when I talk about southern I mean southern in the Northwest Territories, when we find among these Indians in the south part of the Northwest Territories, we did not find in the Indians and Eskimo a type of elderly diabetes although we did get this high blood sugar at times, which Dr. Schaefer has mentioned, this again was associated with diet. I've seen this in the Mediterranean where we had a very high percentage of diabetes with hemorrhages in the eye in older people who were constantly filling up on very rich pastry with a lot of butter in it. These people had diabetic cataracts, hemorrhages in

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1
2 the **eye**, and failing vision. It was very difficult
3 to deal with but we never found this in our northern
4 Indians or Eskimo who were living on their normal
5 diet.

6 Due to increase in blood
7 pressure\$ as we got further south, we also found
8 changes in the retina which lines the eye. The retina
9 is a very delicate nerve layer easily upset by
10 impairment of circulation. We also found that the
11 eyes of people with high blood pressure change,
12 especially at the centre of sight, which is known as
13 the macula, we find pigmentation there, sometimes
14 little tiny dilated swellings on the arteries, and
15 in the later stages of high blood pressure we get
16 bleeding, impairment of sight, often leading to
17 blindness.

18 This was a condition that
19 formerly our nordic Indians never got. As we moved
20 further south we began to find cases of such
21 conditions where the Indians were changing their
22 lifestyles.

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2 I notice that in the
3 "Reponse to Information Request for Socio-Economic
4 Supplementary Concerns" put out by the Imperial
5 Oil Company, they say "added and regular income could
6 promote better housing, improved nutrition for the
7 native population, particularly long-term benefits
8 and improved health should accrue". They seem to
9 consider the white man's diet is healthier than our
10 Nordic Indian's but I'm sure it is the contrary.

11 How are they going to get
12 houses where no houses are available? Houses have
13 to be built and I'd like to know if the pipeline
14 proposed to build the houses for these people.

15 The native food, when
16 plentiful, I think has been proved over and over again
17 is better than the whites who come up here. But what
18 happens when the native man goes to work on the
19 construction area for the pipeline? What is going to
20 happen to the mother at home? She has to look after
21 the house and has an additional burden of complete
22 control of the children. When her husband was there,
23 especially in the more Nordic regions, he could go out
24 for a day's hunting. He could get his moose or his
25 caribou or go fishing. The children are going to
26 school, so who is to do this now?

27 The women don't go out to
28 hunt for caribou or moose. Not normally. The children
29 may snare a few rabbits. Mother has to rely more and
30 more on store food and the further north you go, the

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less easy it is to obtain good food and "the more expensive it is. Her budget is going to be doubled or tripled in order to get sufficient food for her children. Again they will be getting this inefficient store food and the result in the eyes of the children will be detrimental, and also in the mother's eyes. I don't think it's going to be of any advantage.

It will also affect their teeth as Dr. Mayhall has also reported. The report says there will be better medical and dental facilities. The health services at present are finding it extremely difficult to attract doctors up here. A lot of them just don't want to come North. They want to go to the cities, our young doctors. There are not enough specialists to go around in Canada and there'll be more of a shortage in the future.

I'll now talk about alcohol abuse. So, now we turn ^{from} the question of diet to alcohol abuse. The abuse of the alcohol they say might be caused by additional income but this is not necessarily true. There is a different pattern of alcohol used all over the North and it varies from year to year I found as I went around in different settlements.

You seem to get 'settlements which are hit with real severe drinking problems. Some of them recover in the course of time. Some of the natives pull themselves together and some of the young are revolting against what they've seen in their

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parents and in others the parents for the sake of their children, are also stopping drinking and seeking assistance from A. A. I know in one Nordic settlement when I was there a few years ago, all the elder people were drinking with disastrous effects but now a number of them have pulled themselves together and have been out and sought treatment for their problems and they're helping others in their own settlement.

Now, I'm going to show you the traditional drinking patterns. Now, in the normal Indian drinking pattern, drink was only used by the Indians to celebrate certain occasions. The end of a caribou hunt, an alcoholic drink by some Indians was made from the fermented juices of the caribou stomach and among the Loucheux, I know the older ones have told me that there was a type of plant, I think it must have been a mushroom, from which they made a drink and celebrated.

I've also found among the Eskimo, again it must have been a ritual before drum dances; they take the fermented seal's flipper, chew on it and this would make them feel excited and have the same effect as drink and they would have their drum dance. Dancing made them more energetic and then they would sleep for a long time.

Now, the traditional drinking patterns of the whites: This is the usual drinking pattern of celebrations, Christmas, weddings, et cetera. Cultural, wine with meals, as in Europeans. Social

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1
2 drinking with friends in bars. Medicinal, after
3 illnesses and to relieve tiredness, worry, frustration.
4 This is just the pattern, not the abuse.

5 The native patterns were
6 simply celebration and they didn't occur often and
7 they were certainly not chronic alcoholics. Now, a lot
8 of the natives have drunk because they've lost their
9 identity. They feel they don't fit anywhere. They
10 don't fit into the white man's world because they
11 haven't sufficient education. They can't go home
12 because their home life was interrupted by going to
13 residential schools when they were young and they've
14 lost all their native skills.

15 Children often cannot
16 communicate with their grandparents. The tragedy
17 of the child who's only brought up with one language
18 instead of learning more than one is great is northern
19 culture. How difficult it is if you cannot speak
20 the language and if you've no knowledge of the
21 customs and traditions on how to deal with situations
22 in different areas. /It's Not my place to go into detail
23 here but in Indians, the presence of the white man,
24 was more money, better clothes, education and
25 housing, can give more to his family, makes him feel
26 inferior. The only time many of them can really let
27 themselves go and express that feeling and dislike
28 is when they get up the courage with drinks.

29 This leads to excesses with
30 loss of jobs, and a pattern starts. Sometimes they

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pull themselves together. Sometimes they do not. Lack of communication and the feeling of a man who's been treated like a child with the white also leads to this condition. This feeling has begun in childhood.

A few years ago a group of Dogrib children were sent from Fort Rae to Fort Smith to school. They were very young children, some of them only about eight or nine. They could not speak English. I was simply told one day there was six children, none of them could see and they were all rather stupid, who had been sent to see me. I came into find six pairs of terrified eyes who looked at me in fear and dismay. Luckily, I could speak a few words of Dogrib: it was only a few, but the reaction was tremendous. They started up from where they were sitting, came running around me. They went to my room. They were playing on the floor. I checked their sight and I found the following: all of them could see. They could not understand English. One child was stone deaf and could only lip-read in Dogrib and could not do so in English. People do not seem to realize unless they've suffered from it and I have on times, how awful it is if you cannot communicate due to language barriers.

This is not the only case. I'll give you another example. There have been people, this one person sent into assess the children's intelligence, again the Dogrib at this one incident,

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and this was in their own community. A lengthy report was written saying these children were all mentally retarded. This report was read by a French nurse who was situated there and found similar difficulties in communicating in English. She was furious. She went to the person concerned and said, "Why do you say this?" They said, "Obviously", and she said, "Did you test them in Dogrib?", and the answer came back, "No, of course not". "Well", she said, "if you asked me similar questions which you asked the children, I probably couldn't answer them". Suppose we try. She then proved her point quite successfully because her English was inadequate and she couldn't understand. Our lack of communication is a very serious problem and people who come up North don't always realize it.

I was asked by a very great gentlemen, the late General Vanier what I thought of our methods of acculturation. I said, "If you took a white child and sent him to Japan, put him in a Japanese school with no knowledge of Japanese, where he was told his religion was wrong, his parents were wrong, the way he ate and lived was wrong and then after some years, flung him back in his own community; he would be floating in limbo, as many of these people were in the North.

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If questioned, the native will often obligingly say "Yes" to everything, hoping the white man will finish talking and go away. Due to this lack of communication and lack of understanding, resentment and frustration can be caused on both sides.

But I do know when I have been in places where there have been construction camps before, the whites have come into the settlements and drunk with the Indians, even when the construction camps were well away, and under the influence of drink there have been fights between the whites and Indians. There are bound to be jealousies if the white man takes up with native women, and the natives resent it.

Providing added employment will not lead to a reduction of feelings of inadequacy, nor, I think, will it lead to less alcohol abuse. The feeling of inadequacy is not just momentary and it leads to plain resentment.

It arises, too, from a different sense of values. Why should the inhabitants have to learn all about the white man and the white man know nothing about them, and make no attempt to learn? The white man is a child in the bush, just as much as the Indian is a child in the city. When I have been in the bush with them and they have said, "You're the boss," I have said, "I'm not the boss; in the bush you're the boss. In the town I may be the boss."

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We are going to get fighting in bars, we are going to get people injured, and we're going to get far more eye injuries. This has been steadily on the increase ever since the increase in white population up here, and the increase of workers who come temporarily to the north, whatever project they've come for.

Some people adapt more quickly than others; others cannot. So what happens? We get the chronic drunks and the children are neglected, they don't get enough to eat. But I think this is often less amongst the Indians than the whites, and you cannot lay down hard and fast rules.

I want to show you the statistics that I've compiled in one place alone. I have got it up to '70 in all the places, but this is just to show, this is injuries due to violence that came into Fort Smith Hospital. You will see the percentage of T.B. went down, 26.82 in 1959 of total admissions, and only eight in '74. Whereas violence went up from 2.5 to 29.48. Sometimes there have been fights between the Indians themselves, but this has all been injuries due to drinking, and sometimes fights between Indians and whites.

Now, alcohol can lead funnily enough to an increase in congenital diseases:

1. through drunkenness in the mother;
2. through injury to the baby at birth with the mother being drunk;

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3. due to what we call consanguinity, that is to children born as a result of sexual intercourse between closely related people.

The Loucheux kept strict tribal laws against consanguinity, and have the lowest number of congenital ocular defects, that is particularly among the people of Old Crow. Other tribes who do not keep these laws, have a noticeably higher percentage of congenital defects.

When there is more drunkenness, the laws against intermarriage are not kept strictly. One Indian girl told me that incest under the effects of drink has occurred in her settlement and that there have been relationships between brothers and sisters. The resulting children are not told of this but the elders all know, and are trying to revive their tribal laws and are fighting off drink because of this.

We also find that drink is playing similar havoc among the Eskimo. We do know there is a higher percentage of consanguinity because at times they have changed wives on the trail with their friends. They are aware of the results of consanguinity but because of this exchange of wives, there are a number of marriages between close relatives. This exchange is not done as a general custom, but only among friends or as an economic necessity.

There are certain diseases

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which do not exist in the Indian and Eskimo, but which do exist in the white, and are only brought in with white blood. That is when you get mixed blood, heterogenecity.

1. retino-blastoma and melanotic sarcoma. These are all forms of cancer of the eye, in the North-west Territories have only occurred with the introduction of white genes. All the people concerned -- and I know all of them -- were 25% white. This disease has been a killer, but luckily there are very few in number.

2. neuro-muscular diseases, that is weakness of the eye muscles with loss of binocular vision, that is the ability to judge distances and shapes, are also another condition which occur far less in the Indian and Eskimo than they do with the introduction of white blood in the Metis races and in the Caucasian.

Now the total number of muscle weaknesses, eye muscle weaknesses of all kinds, not only including the ones due to heterogenecity, are, in the Indian, 1.86; Eskimo, 1.19; Metis, 6.4; and white, 5.3.

There is a very common stabismus which also runs in families amongst whites and is never seen in the Indian and Eskimo, unless white blood is introduced. Funnily enough, there is also a particular type of stabismus which I found only occurs with mixed blood. This particular type of muscle weakness is a congenital one. It occurs in

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several members of a family whose mothers' and fathers have been white on one side, Caucasian on one side, and Indian or Eskimo on the other. It is a dominant character that is handed down to successive generations. I found evidence of this in many others besides the numbers I give here. Here are statistics of the same.

Now this shows the different types of muscle weakness. As you see, I've taken it quite among a number of people, amongst the Indian, 1,004; the Eskimo, 1,918; the Metis 609; though again I've done it all ~~in the~~ nordic areas and the whites, 621.

Now, when you get the other types of stabismus, you see that in the Indian and Eskimo there's a certain type I call congenital and familial, and that is a type which only occurs where there is mixed blood. Now in the cases of the two whites who are so-called white, I was very suspicious of the antecedents of the mother, but if you look at the Metis you will find 66.66% of all cases of stabismus where there is congenital and familial. There is another thing which I can tell you in a moment, or show you in a moment. The cases of congenital stabismus, that is muscle weaknesses of the eye, are on the increase in every group. This has been also found in many countries of the world. The Arabs, the Muslemen have a habit of marrying off first cousins, and they're finding more and more not only congenital weakness of eye muscles, but many more

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congenital defects, and^a very modern professor whom
I admire greatly because he's against the habits of
the Muslemen are trying to prevent this, and they're
trying to stop first cousins marrying.

In some of these cases a
muscle weakness are not obvious; others are the
ordinary cross-eye or one eye that wanders out. All
those are classed as stabismus and they are simply
due to a defect sometimes in the brain when they are
congenital type, and sometimes in the eye muscle,
injury to the eye muscles themselves.

Now can I have the next?

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Now, if we examine the whites we will find in those--this again was the last time I saw this particular group of people ^{was} in 1970 and the ones who were born before forty, the congenital was 1.65 and in the children it had gone up to 4.69 in the ones born between '60 and '70.

The congenital and familial, except for that one family, did not exist. As I say, I think the wife had Indian blood in her. The accommodative strabismus is a strabismus which we do not find amongst the pure blooded Indian or Eskimo. Again, it has formed quite a high percentage of the total number of strabismus amongst whites and Indians. It stays fairly stationary, the percentage.

Now, you see where there's mixed blood, that is breeding between the Caucasians and the native people has resulted in this high percentage of congenital and familial defects in the eye muscles. Accommodative squint strabismus, this particular type of weakness which is present in a high percentage in the whites is also found in a few Metis.

We'll have the strabismus now on the Eskimos. They are other types. You'll notice if you have an injury to the eye or if you have an infection in one eye or if you've had tuberculosis. Those cases where it says among the Eskimo are following systematic infection, they were all due to tuberculosis affecting the eye muscles or

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the brain. It followed meningitis in some cases in these children or it was a natural tubercle which had formed in the brain itself.

Local infections too were in a number of cases, due simply to tubercular infections of the eye which hadn't been treated and where the sight was destroyed in the one eye. We also notice a very funny thing. There's a very low percentage of congenital diseases among the Eskimo born before the '40's which I will show you. Have you got the next one? Way back to the date of birth in decades--this is the Eskimo. You've got two of those.

Now, the date in decades you find that the congenital have increased again from 0.36 up to 1.4. Can I have the next? You can study this at your leisure. Now, with the Indians we notice again that there is no accommodative strabismus like in the whites. There is a certain amount of congenital strabismus and the totals are very low. If you remember in the Indian and the Eskimo, the total percentage of strabismus of any kind is low.

What's the next one? Now, this is showing the different Indian tribes. Arctic Red, the congenital was high and they were not nearly as strict as you see. Old Crow where they were very strict against consanguinity had no congenital cases of muscle weakness of the eye; where Arctic Red, where they were not nearly so strict, had 2.29%. You'll also

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notice in Fort Franklin there was a fairly high percentage and in Good Hope again. They're not so strict against consanguinity; the various causes have been due to drink again, the abuse of alcohol.

Can I have the next one please. That's all. There was a thing that I would like to have brought out. I'd like to say a final decision. No one individual group can decide on such an important question as this. It is up to the people of all walks of life who ^{have} studied it to come to a decision of what should be done for the best of the country at large and particularly for the people who inhabit the north.

How much is the country going to be destroyed? If it is, and if it does destroy part of the country, how much is it going to affect the rest of the country, especially if the sea is polluted?

With the advent of large construction camps we are going to have a rapid increase in diseases and conditions prejudicial to good sight of the native and probably also to the white workers. Firstly, the diet. I have eaten at a few construction camps. The food is plentiful but fatty, starchy and sweet. Instead of adequate salt in the cooking, the men add far too much salt as there's been no salt in the cooking and they eat pickles, chutney, et cetera, to season it.

Effects will be as stated,

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"wives and children at home and the men in camps with the result in an increase in ocular diseases associated with diet".

Lack of communication and understanding, loneliness, fear and jealousy will lead to excessive drinking as a relaxation, with resulting increase in crimes and violence and loss of sight. This applies to whites as well as the natives.

It will also lead, in the case of the natives, to lack of the following of their tribal taboos, and an increase of inbreeding and other diseases such as an increase of blood pressure, et cetera.

Children of mixed born will be blood--children of mixed blood will be born and liable to inherit the diseases of the white's. Cross-eyed, short sighted people are handicapped in this country and so are people with cataracts even if operated on them. Open angle glaucoma, which is being found more frequently in these cases of school myopia, defective vision due to high blood pressure and Diabetes will also take their toll.

MR. BAYLY: Mr. Commissioner, that completes the Evidence in Chief of this panel and the panel is now available for cross-examination.

THE COMMISSIONER: Just before you begin, Mr. Scott. Dr. Schaefer, you said that venereal disease in the Northwest Territories is declining now; that this was a perceptible thing during

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3 the past six months or a year and you were fearful
4 that if a pipeline were built and developments came
5 with a great influx of people, that this improving
6 trend in V. D. statistics might take an upward swing
again.

7
8 Now, that was essentially
9 what you said, wasn't it?

10 WITNESS SCHAEFFER: That's
11 right, sir. For the first time in eighteen years
12 there has not been a steeply upgoing curve. It seemed
13 to level out in 1974 to '75 and for the last eight
14 months, I just got the figures last week that were
15 revealed at the Regional meeting; we have for the
16 last eight months--all it was in the Northwest
17 Territories, but particularly in our highest incidence
18 areas such as Inuvik, a decline, which reached in
19 some areas as high as forty percent and in other
20 areas around thirty percent, which is unheard of and
has not occurred since eighteen years.

21 One might be very critical
22 about taking any conclusion from an eight month period
23 and I would myself be critical but coming after a
24 year of plateauing, I believe that is a very hopeful
25 sign indeed. It seems to indicate, as I interpret
26 it this morning, as perhaps a hopeful sign of stabilizing
27 that until then almost hopeless trend in
28 deterioration of what I would call social diseases.

29 Q Yes. Well, what
30 was the experience of venereal disease? That is, it can

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2 be treated with penicillin, I understand. What were
3 the long-term consequences of its prevalence? What
4 are the long-term consequences of its prevalence?

5 A I must apologize for
6 my hearing.

7 Q I'm not putting it
8 fairly. What I'm saying is, we all know what
9 tuberculosis did to the native people before it was
10 arrested.

11 A Right.

12 Q Right. Is there any--
13 and it appears that until this very recent development,
14 V. D. was endemic among young native people. That's
15 what I gathered you were saying. Well, I thought
16 that venereal disease was something that could be
17 treated swiftly and that could be cured swiftly in
18 the way that say tuberculosis could not be until
19 medical science perfected drugs for treatment. Am
20 I making myself clear or is it--

21 A Yes, I think I understand
22 perfectly what you're aiming at and in many respects,
23 you interpretation is right. Venereal disease, if
24 recognized early and treated early is in most cases
25 cured without consequences. However, this is not quite
26 so if it is delayed in diagnosis and treatment, it
27 leads often, not always, but in a significant number
28 of cases in female infertility and even infertility
29 and secondary diseases of other sexual organs.

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2 It also does contribute as
3 now it is recognized world-wide over and this
4 recognition which has dawned on us in the last decade
5 or in particular in the last five years, it has
6 something to do, the prevalence of venereal
7 disease with the occurrence of cervical cancer and
8 we--

9 Q Cervical cancer.

10 A With cancer of the
11 cervix at the lower part of the womb in women. This
12 is now recognized. It follows usually the high
13 rates of venereal disease in the population. Twenty
14 years later followed by a very high rate of cervical
15 cancer. This has come out of studies from the U. K.
16 as well as in the United States and we certainly
17 have confirmation of that in our northern native
18 population.

19 There is another complication
20 that my colleague just draws my attention to.
21 Tubal pregnancy can occur. It's a frequent compli-
22 cation of frequent or chronic gonorrhea in women.
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2 Q What did you say, what kind
3 of pregnancy?

4 A Pregnancy occurring in
5 the tubes rather than in the womb.

6 Q Yes, yes.

7 WITNESS MAYHALL:

8 A Causing acute abdominal
9 disease and maybe death if not urgently treated.

10 Q Sorry, I didn't get
11 that.

12 A Tubal pregnancy is
13 a very dangerous clinical situation which often leads
14 to emergency operation and if not treated, leads to
15 death.

16 Q I follow you.

17 WITNESS SCHAEFER: May I sir,
18 ask your indulgence to elaborate one point which I
19 may have made myself not clear enough? I said there
20 was a constantly and upgoing trend for 18 years in the
21 rate of gonorrhea in the Northwest Territories, but it was not
22 endemic and not high.

23 Q Not what?

24 A It was not endemic and
25 it was not higher than in the rest of Canada, 18 years
26 ago. It started at a much lower level than anywhere
27 else in Canada. 18 years ago we started out with a
28 rate of gonorrhea which was significantly lower than
29 the rest of Canada, but since then it has incessantly
30 been going out and exceeds now the multiple of the
31 rest of Canada.

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C ross-Exam by Steeves

Q And exceeds now what?

A The rate in the graph which I did show where the rate of Canada was lower down at the bottom, it was in the Northwest Territories the last years completely reported which was on the graph '73 to '74 was a multiple, and I would have to look up my file, it was something in the range of 20 times for the rest of Canada.

THE COMMISSIONER: Yes, Mr. Steeves?

CROSS-EXAMINATION BY MR. STEEVES:

Q Doctor, when you were answering the judge about the statement you gave in evidence, of stabilizing periods in the incidence of venereal disease? I'm sorry, I didn't catch all of your answer. You said, you tried to explain what you meant by that and I'm sorry, I wanted to ask the same question and I didn't get your answer.

A Since $1\frac{1}{2}$ years that steeply upgoing curve has taken a turn. It turned for one year into a plateau, and for the last eight months has fallen by the rate of 30 to 40% in the Northwest Territories.

Q When you say "something stabilizing", all you're saying is the rate, is that right? The rate of infection or the amount of infection.

A Yes, there are different terms used under epidemiology that those people who

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2 study the prevalence or incidence of diseases. Perhaps
3 the prevalence would be the right term.

4 Q Thank you, and you weren't
5 speaking about stabilization of anything that had to
6 do with the cause of this rate, or prevalence?

7 A Well, I would go into
8 the field of hypothesis if I would elaborate on it.
9 My personal impression is there was a slowing down
10 of that -- of those influences which in the years be-
11 fore were speeding up everything. Perhaps it had
12 something to do with the slowing down of industrial
13 activity which has been experienced over the last
14 1½ years, in that same more sensitive areas like
15 the Mackenzie Delta. But I want to emphasize, this
16 is a hypothesis for which I have not a very firm
17 basis as on my other medical evidence.

18 MR. STEEVES: Thanks very
19 much. Thank you, sir.

20 THE COMMISSIONER: You said
21 it's a correlation, but you can't go any further
22 than that.

23 A I would be more cautious
24 in saying "correlation". It is my hypothesis but I
25 am not firm on that.

26 WITNESS HILDES: Mr. Commis-
27 sioner, might I ask Dr. Schaefer if there were
28 changes in treatment methods during that time?

29 WITNESS SCHAEFER: The most
30 important changes in treatment methods for gonorrhea,

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were are enacted some four or five years ago when we added, made it mandatory to add benamit to the penicillin treatment which causes, ^{/causes} a longer and higher blood levels of penicillin and therefore are more effective. But those changes proceeded the down-turn and I do not think they had that much to do with it. They helped to some degree, but I think it was not that essential for the last down-turn.

THE COMMISSIONER: Excuse me, I was just looking at all the charts. The one on venereal disease wasn't included with the charts. Sorry, go ahead.

MR. SIGLER:

I think, Mr. Commissioner, because of the way the panel has developed their positions and their opinions I have no questions to get any more details from them.

MR. SCOTT: Mrs. MacQuarrie?

CROSS-EXAMINATION BY MRS. MACQUARRIE:

Q Dr. Schaefer, in your statistics regarding venereal disease, you did mention that gonorrhea is levelling off. Did these statistics include syphillis as well?

we are in
A Yes, /a very fortunate position, Mrs. MacQuarrie, that in the Northwest Territories, we have very little syphillis so far. As a matter of fact in the Inuvik zone which so far has been our main problem area. We haven't one case. A similar

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2 observation was made in Alaska until I came across a
3 recent report that for the first time in the last
4 decade, last year they now have syphilis on the North
5 Slope. One of the explanations for that is that this
6 is medically difficult to understand, with such a
7 rate of gonorrhea and then there is a parallel
8 situation usually, any place in Canada or for that
9 matter any country where we have good reporting
10 statistics from, that the syphilis rate would be
11 much lower than the gonorrhea rate, usually runs
12 parallel to it. But not so in the Northwest
13 Territories, not so in the natives of Alaska until
14 quite recently at least. Why? One of the reasons is
15 we have a better reporting system in the Northwest
16 Territories and a much more tight treatment system
17 there, early treatment system, which likely aborted
18 syphilis cases quite early with our heavy dose of
19 penicillin plus benamid being used.

20 Q Is it likely that the
21 increase in uterine cancer is only being seen now
22 because of the better methods of testing for cancer?

23 A Mrs. MacQuarrie, this
24 is unlikely, although I admit that we do see and
25 discover now uterine cancer, particularly cervical
26 cancer, at an earlier stage, but women with cervical
27 cancer not discovered early will go onto death, and
28 no Eskimo has died in the Northwest Territories where
29 the cause of death was not revealed in particular
30 in a case like cervical cancer, which is easily seen in

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2 late stages. We can give the assurance there is
3 no group in Canada who has been so regularly receiving
4 health service and health explanation than the Eskimos
5 and the Indians of the Northwest Territories, as a
6 group. It is not only most unlikely, it's actually
7 excluded in the case of cervical cancer that we would
8 have overlooked at least for the last 20 to 25 years,
9 advanced cases of cervical cancer.

10 Q Thank you.

11 In your paper you mentioned
12 the vitamin deficiencies perhaps Vitamins A and D
13 are primarily the vitamin deficiencies that occur.
14 Would this contribute to a poor resistance to viral
15 infections then?

16 A I think that's a good
17 point, Mrs. MacQuarrie. Vitamin A has indeed been
18 suspected by a number, not only of nutritionists but
19 people working in the infectious disease field, perhaps
20 to contribute to a lower resistance of the covering
21 of the skin, the epidermis as well as of the covering of our
22 respiratory tract and gastro-intestinal tract. I did
23 not -- yes, I did mention in my paper that Nutrition
24 Canada found in regard to Vitamin A that this was
25 a critical area in nutrition for Inuit as well as
26 some Indian groups. I must say this is possible that
27 has something to do with lowering of resistance, yes.

28 Q Although your paper
29 seems to be confined mainly to the native people,
30 do not the whites who come to live in the Territories

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Cross-Exam by MacQuarrie

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2 and change their lifestyle and dietary habits also
3 become prone to the many viral infections that occur
4 in the north?

5 A I am sorry, the last
6 part of your sentence?

7 Q Since your paper is
8 confined mainly to native people --

9 A Yes.

10 Q -- don't whites who come
11 to live in the Northwest Territories and undergo a
12 change in their lifestyle and dietary habits also
13 become more prone to the viral infections that are
14 around in the north?

15 A I would say they are
16 more subjected to similar climatic strains, particularly
17 the strain of cold air on the respiratory tract.
18 Yes, in that regard I must say the whites may be
19 subjected to similar pressures. They are, however,
20 most of the whites so far have had less infection
21 pressure because of the ratio of persons per room
22 and so on that has nothing to do with housing, there
23 are a number of other factors that seem to be
24 more in favor of the white population segment of the
25 Northwest Territories so far than the native segment
26 of the Territories.

27 Q O.K. For instance,
28 I was thinking of otitis media, which seems to
29 affect all children in the Northwest Territories,
30 no matter how well-fed or well-housed they are.

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1
2 A I think that's a very
3 good point, Mrs. MacQuarrie, and that is a point
4 which although Dr. Hildes made some very pertinent
5 remarks, I missed in his enumeration of complex -- of
6 the complexity of this problem and that is the fact
7 that in a northern climate your respiratory tract
8 of which the middle ear is part, through the connection
9 with the upper part of the respiratory tract, the
10 eustachian tube goes to the middle ear as part of it,
11 we have in the north perhaps because of the change
12 of very cold, extremely cold air and indoor warm air,
13 a very dramatic influence on the respiratory tract
14 including the middle ear, which may make those
15 structures more prone to infections. That's true.

16 Q From my observation,
17 the number of infections that occur in the Northwest
18 Territories are treated with a variety of antibiotics
19 and often result in people being -- developing a
20 tolerance to antibiotics. Do you envisage then
21 that in the future there may not be an antibiotic
22 that would cope with the various infections, including
23 venereal disease, that occur?

24 A I share with you your
25 concern of the unwise use of antibiotics when they are
26 not needed, and we are also not just concerned for
27 losing the sensitivity of certain bacteria, becoming
28 resistant to that type of antibiotics; I also in
29 addition I have the concern of developing sensitivity
30 so-called allergic reactions to antibiotics such as

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do in a small percentage of persons develop sensitivity to penicillin, for example. However, fortunately and here I must praise modern development, modern science, they are constantly developing new antibiotics which help us to overcome some of those problems you spoke just of.

Q Miss Noble, on page 8 in your presentation, you mention that COPE has recommended that medical staff come into the Northwest Territories, undergo an orientation period. At a Canadian Mental Health Association meeting with Dr. Colvill in March of '75, I believe, he agreed that this was a necessity and I understand that the -- since then this program has been developed for the nurses coming into the Northwest Territories. Do you know if this is so?

WITNESS NOBLE: You said in March this year?

Q '5.

A '75. Now I've never been actually on one of the programs. I've talked with some of the nurses who have been. There is supposedly some form of orientation and I talked with Dr. Pat Abbott about this. How effective it is, what areas it covers, you know, I'm not really familiar with. But some of the nurses I've talked with they don't seem to feel it's too effective or really prepared them for the social and cultural situations that they were going to be finding themselves in in the settle-

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ments. We have made some recommendations in Inuvik in terms of literature and offers to meet with incoming medical staff. So far nothing has developed from this.

Q Also you mentioned that mental health programs need to be expanded. What is the current level of mental health programs available in the Inuvik region?

A Well, as I said in my testimony there is a public health nurse and Dr. Abbott does visit, I'm not sure how many times a year. Now other than that, I am not aware of any mental health services except really on a voluntary basis in terms of which people make themselves available, such as Sam Raddi and Nellie Cournoyea, for calls any time at night to help families through a particularly stressful moment, or one thing or another. Certainly in the settlements I'm not aware of any at all either. There is the local social service worker in each one of the settlements. But usually the load of work on him or her is such that there simply isn't any time available, or hours in the day to do much except you know, the basic work that has to be done in the office.

Q You also mentioned your concern about the availability of interpreters. Is there a staff position at the Inuvik Hospital for an interpreter?

Noble, Cass, Hildes
Mayhall, Schaefer
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1 A To my knowledge, at
2 this point, no. We had discussed this some with the
3 acting zone director and we have given -- there is a
4 new zone director there, Dr. Jeyachandra -- and
5 given him a copy of COPE's health brief and had some
6 discussions with him. He felt many of the points
7 were quite valid and in fact he circulated the brief to
8 all his staff and said he was going to start to try and
9 work on some of the problems that have been outlined in
10 that brief.

11 Q I see. You also
12 mentioned the need for community health workers.
13 National Health and Welfare had the program where they
14 trained "X" number of community health workers per year.
15 In 1975, they trained eight. At the end of the course
16 they had perhaps three working. Do you know how many
17 community health workers are presently employed in the
18 Inuvik region by National Health and Welfare?

19 A I haven't been to some
20 of the central Mackenzie settlements for about a year
21 now. I believe ~~and you know I stand to be corrected~~ on this
22 because there is a turnover in some of the settlements.
23 Payscales are low. There is one, I know of in
24 Tuktoyaktuk and she has been there for some time and
25 doing a very excellent job.

26 In Inuvik, I -- there
27 is a public health nurse in Inuvik. I don't believe we
28 have any community health workers. In Fort Good Hope
29 there is one or two possibly. Whether they are still
30 in that position now I don't know.

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Q But their main difficulty is the poor wage scale then, is it?

A I think that may be part of it. I think one of the other concerns is, you know, how aggressively are such people sought out, and what sort of training are they provided with. There is a lay dispenser for instance in Paulatuk that's been there for some time and I was recently talking with her shortly after Mr. Berger was in there about you know, upgrading, continual upgrading and courses and opportunities for people to improve their knowledge of skills. There was sort a bit of a laughter and she said, "What upgrading?" She had sort of an initial basic course and that was it.

Now, this was in contrast to what I found in Alaska. I spent some time with the community health worker in Steven's Village which is an Athabaskan Indian community to the northwest of Fairbanks. Now, there she has received continual training. She has been there for eight or nine years in that position in the community. She has had continual opportunities and training courses and doctors coming in every single year to upgrade her skills and technical ability.

Q You mentioned that there is a community psychiatric nurse in Inuvik for the city or for the town rather or for the zone?

A It is a public health psychiatric nurse that I mentioned that's sharing duties with public health on a part-time basis was the

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1 psychiatric nurse. From what I understand -- I haven't
2 talked with Dr. Abbott or her recently. Much of her
3 work was of the consultative nature; in other words,
4 helping out with many of the problems that the doctors
5 and nurses face and their adjustments in dealing with
6 patients. As well as being a source of information and
7 help to others in the community like schoolteachers who
8 may be having difficulties with children in not under-
9 standing what's happening.

10 Q Would her time be
11 divided between the public health aspect of nursing
12 and the community psychiatric aspect then or --

13 A This is -- that was
14 what I understood last time I talked with Dr. Abbott.
15 He has been -- he may have freed her now. He was
16 working to free her to go into full-time in the psychiatric
17 area.

18 Q I see. You mentioned
19 that there are no detoxificat^{ion}/facilities in Inuvik.
20 Are the patients then evacuated to the Northern Addiction
21 Service in Yellowknife or are they sent to Hemwood in
22 Edmonton or Poundmaker, do you know? Or what care do
23 they have?

24 A The local Inuvik jail.
25 To my knowledge, there is nothing else unless, you know,
26 some person is going into convulsions or whatever and
27 I'm not an expert on alcohol. I imagine they would be
28 taken to the emergency ward of the hospital but there
29 is no detox center there at the hospital.
30

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Q But you have a large
drunk tank at the jail?

A It's not really a
drunk tank. It's just a jail, a pretty sad one too.

WITNESS HILDES: May I
comment on the interpreters? I don't know about the
other zone but in the Keewatin zone I think there is
an official interpreter employed by Health and Welfare
in every nursing station. I think one of the problems
that I have heard happen is her availability after
hours. But she's I think available regularly. In
addition to that Health and Welfare provide the University
of Manitoba with the funds to provide an Eskimo-speaking
interpreter for the Churchill Health Center and also
an Eskimo-speaking interpreter for Winnipeg.

Q Dr. Hildes, is this
fairly recent?

A It has been going on
as far as the interpreter at Churchill and Winnipeg
about three or four years and as far as I know there
has been interpreters employed in the nursing stations
in the Keewatin ever since I have been involved.

Q Is that person -- the
official interpreter in the nursing station -- is that
their main function or is the maid and janitorial
service their main function and their interpreter job
secondary?

A No, I think it's the
main function. I think that there is -- that they have
maintenance personnel or janitorial people look after

Noble, Cass, Hildes
Mayhall, Schaefer
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1 vehicles and they have part-time kitchen help. I'm
2 talking about someone who is employed primarily as an
3 interpreter.

4
5 Q I see.

6 A Now, this may not be
7 fully utilized in all nursing stations. If you have
8 a small place like Repulse Bay, the interpreter may be
9 not on a fulltime basis but may be ad hoc depending
10 on the clinics. But I think in the larger settlements
11 like Eskimo, Rankin and Baker, that's a fulltime
12 position, I think.

13 Q Well, this somewhat
14 conflicts with Dr. Abbott and Dr. Colvill's position
15 in not being able to hire interpreters for the
16 Western Arctic and also for the Charles Camsell Hospital
17 in that there were no -- there was no government
18 position established for an interpreter so therefore
19 they needed to use the domestic staff in an interpreter
20 capacity as the need arose. So I just wondered if
21 that had been changed in the past year.

22 A I think in Churchill
23 and in Winnipeg, I may say that there was not an
24 official position but I pushed hard to establish that
25 in the contract I have with Health and Welfare.

26 Q I see. Also they
27 are available then in the communities?

28 A Well, the ones in
29 the communities I have nothing to do with. I just know
30 that they are there when I go to settlements, I find
reasonable interpreter services.

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Mayhall, Schaefer
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Q Dr. Schaefer, then,
would you know whether the Camsell hires
staff interpreters?

WITNESS SCHAEFER: I know
that they have not a fulltime interpreter. They make
them available of the services at a fee for a service
basis of an Eskimo lady who comes from the delta which
lives now, is married in Edmonton and has been doing
so for awhile.

We often have and this
was part of the reason for keeping concentration of
Eskimo and Indian patients in the Camsell Hospital the
opportunity, not only that they can socialize with other
Inuit and Indian patients on other wards but often we
have then recuperating patients available as
interpreters.

I would certainly be
very much in favour if such a permanent position could
be established. Unfortunately, the referral
practice over the last two years has rather declined
our influx of Indian and Eskimo patients from the
north and therefore will have contributed to the lack
of incentive or let's say the loss of economical reasons
for this position.

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Q Dr. Hildes, if your interpreters are available in Winnipeg and Churchill, are they also available at the mental hospital at Selkirk or wherever native people go in Manitoba for treatment?

WITNESS HILDES: As far as I know, at the present time there are no Inuit patients in Selkirk or Brandon. We did have one very long stay patient there that our interpreter went out while he was there, went out on a slightly irregular basis but a couple of times a week, mainly to socialize,

Q I see. Since the Selkirk Hospital was no longer accepting the mentally ill patients from the Northwest Territories, where do these people go?

A Mrs. MacQuarrie, I did not say they were not accepting them. I think as explained yesterday by Dr. Atcheson, we try very hard to treat mentally ill patients, people who have behavioural disorders or frank psychoses in their home environment and I'm quoting from memory which is almost certain fallacious but at the moment I think there was only one patient in the last couple years that I know of from the Northwest Territories that was evacuated for psychiatric illness. I make a correction to that. There was one not so very long ago for a short term assessment.

So, it isn't that Selkirk is refusing. The case I mentioned was someone who was confined by the courts or was not considered fit

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Cross-Exam by MacQuarrie

1
2 to stand trial, many years ago, twenty odd years ago
3 and was confined to Selkirk for a long time because
4 of his mental state.

5 Since I've been involved,
6 the situation that Dr. Atcheson referred to works
7 very well and we try very hard to assess and maintain
8 and treat people at their homes.

9 Q Well, when an emotionally
10 disturbed or mentally ill patient is seen at the
11 nursing station, are there diagnostic facilities
12 and treatment services, rehabilitation personnel
13 available there to look after them?

14 A The acute psychotic
15 episodes are relatively uncommon. Sometimes if that
16 does happen and there is a disturbance at the local
17 settlement that can't handle it, they are often in
18 contact by radio, either with the doctors or with
19 the psychiatrists but sometimes those people, if they
20 have to be hospitalized even for a short period of
21 time, then they do get evacuated down as far as the
22 secondary level of care. But such patients are, when
23 they're seen in consultation by the visiting psychiatrists
24 and they establish a rapport between the psychiatrists
25 and the other visiting doctors or directly with the
26 nurse and sometimes a rapport with the patients
27 themselves for maintenance of treatment and often
28 even between visits, psychiatrists that keep going back
29 and back, may be corresponding with by letter or
30 phoning nurses in order to maintain the level of

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by MacQuarrie

1
2 supervision of patients. "

3 Q Do you find that this
4 is very adequate?

5 A I find it's much more
6 adequate than trying to treat them down south in
7 institutions.

8 Q I see. How often does
9 the psychiatric team visit the communities in the
10 Keewatin?

11 A Annually.

12 Q And who makes up this
13 team?

14 A Well, I was going to
15 comment on the word team. A psychiatrist is
16 sometimes accompanied by his resident. We have had
17 at times clinical psychologists. Some years ago
18 we had a regular roster of clinical psychologists
19 going in. We have had from time to time psychiatric
20 nurses but that's purely on an ad hoc basis and it
21 would be fallacious if I left the impression that
22 there was a big team approach.

23 On the other hand, I think
24 the psychiatrists who go become very--we hope they
25 go back regularly and get to know the community and
26 the people who operate in that community and they
27 do not--they act as advisors to the local net, which
28 is the nurse and the social worker in that community
29 and the community health worker and school teacher,
30 the priests or whatever other resources he may find in

Hildes, Mayhall, Schaefer,
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1
2 that community.

3 Q And this is done once
4 a year? How do you deal with the turnover of staff,
5 the resource people in the community that you would
6 likely consult with? There's no continuity in
7 them in many of the communities.

8 A Most of the people I'm
9 talking about are local people. Now, there is a
10 turnover of nursing staff but I can't answer--I can't
11 quote what percentage of staff turnover per year in
12 any one place. There's no question that's a problem.
13 There's also no question, as Dr. Atcheson pointed
14 out yesterday that sometimes the consultant has the
15 greatest continuity of any and in the Keewatin, Dr.
16 Don Rogers who was a colleague of Dr. Atcheson's in
17 that report in 1968 has been--he made the mistake
18 of moving to Vancouver for a year and then he came
19 to his senses and came back to Manitoba.

20 He's been in continuous
21 interest and involvement in the Keewatin for, I would
22 guess, the last ten years.

23 Q Yes, but perhaps at
24 the people level, the actual mental health services
25 that are resident in a community in the Keewatin
26 could expect would almost nil, is that true?

27 A No, I wouldn't say that
28 but I would agree that there are big gaps. I think
29 at the level of school children with learning
30 disabilities and the problem of assessment of mental

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Cass, Noble
Cross-Exam by MacQuarrie

1
2 retardation and behavioural problems in schools, the
3 need for some sort of regular assessment either from
4 the school system or the health system or social
5 development but somewhere in there, there I think is
6 a gap in clinical psychology for testing and for
7 laying out programs. I think that's the gap.

8 I think there is a big gap
9 in the settlements of people who are actually
10 knowledgeable, experienced, trained and concerned
11 with alcohol programs, although there is now in the
12 Keewatin people who are becoming interested in this
13 and wish to receive training in this and who's
14 responsible for that area, whether that be Health
15 and Welfare, social development, I'm not quite sure
16 but I think there's a big gap there.

17 Whether there's a big gap
18 in counselling, I suspect that there is some gap
19 there. The nurses try their best but many of them
20 are not experienced in this area. Some of them are.
21 So that I wouldn't say that the resources are nil
22 but I do agree with you that the resources could be
23 better.

24 Q Are there established
25 programs in the area of prevention and rehabilitation
26 in these communities?

27 A I^{am} now feeling as if you
28 should have asked Dr. Atcheson these questions better
29 than me.

30 Q No, no. I'm referring

Hildes, Mayhall, Schaefer,
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Cross-Exam by MacQuarrie

1
2 specifically to the Keewatin.

3 A I think the--I'm not
4 trying to sluff off the question but I think that
5 I would say that the visiting program that Dr.
6 Atcheson outlined exists in the Keewatin and perhaps
7 even to a greater degree of more regularity in that
8 all the settlements--we try to visit all the
9 settlements at least once a year.

10 So, when you say established
11 programs, I'm innocent enough not to know precisely
12 what you mean by that. I have indicated that there
13 may be programs of detection and management of
14 learning disability or mental retardation. There
15 are programs of alcoholism. There may be programs
16 of marital counselling, family planning. I'm not
17 quite sure what other programs you have in mind.
18
19
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Cass, Noble
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1
2 Q I'm sorry. "I was a
3 little distracted. Did you say these are already
4 available there or they could be developed?

5 A I said I have alluded
6 to them and I think that they are carried on to
7 whether they are perfect or not, but I think all those
8 activities do go on.

9 Q And they're provided
10 under Northern Health Services or social development?

11 A Or a combination.

12 Q I see.

13 A I would agree with
14 you. I'm acting as if I'm your adversary. I think
15 that you've heard me say that I think that mental
16 health, alcoholism and behavioural problems are
17 very important and I'm not denying that these are
18 important areas. They are also very difficult to
19 manage. But I am saying that the services are
20 not completely zero.

21 Q Yes, I was interested
22 to notice that you mentioned the birth control
23 program. Is there such a thing operating in the
24 Keewatin?

25 A Oh, yes. All the
26 medical services provide information, advice on
27 family planning to people who wish it and I think
28 hold educational sessions and I think that visiting
29 doctors do too.

30 Q Okay. And are they

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by MacQuarrie

1
2 involved with the Northwest Territories Family
3 Planning Association out of Yellowknife or is that
4 a separate Federal Government program?

5 A I have had no contact
6 with the Northwest Territories Family Planning
7 Association, but we do use, certainly at the Churchill
8 level, we use the Manitoba equivalent, which is
9 quite a well organized organization. To what extent
10 the Health and Welfare nurses in the Keewatin District
11 rely on either organization or whether they
12 rely entirely on medical services and professional
13 help and advice from the University of Manitoba,
14 I don't know.

15 I think they mostly rely
16 on their resources that they have in their settlements
17 which are visiting physicians and consultants from
18 Manitoba and they also rely, I think, on the--I hope
19 they rely anyway or collaborate with the social
20 workers of Social Development, N. W. T.

21 Q I see. Then if abortion
22 or sterilization needed to be carried out, would the
23 patients be evacuated to Churchill?

24 A Sterilization, either
25 female or male are certainly not done in any of the
26 Keewatin settlements. They're done in the usual
27 way with people who wish to have these operations
28 done in Churchill.

29 Q And the abortions as
30 well? Therapeutic abortions I'm referring to.

Hildes, Mayhall, Schaefer,
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Cross-Exam by MacQuarrie

A Therapeutic abortions are not carried out in Churchill. Any therapeutic abortions in that whole area that are required are referred to Winnipeg.

Q To Winnipeg?

A Yes.

Q Yes. You used the term nurse-practitioner many times, Dr. Hildes. Could you define this for me?

A To my view, a nurse practitioner is a nurse, a qualified nurse who has had special experience and some training and who's acting as the deliverer of primary care.

Q Yes, special training in what? Special qualifications and training in what area? I wondered here if you're referring to the outpost nursing course that has only just recently been available in Canada?

A Well, when you say recently, I think the Dalhousie Program which is a very unique program has been going for a number of years.

Q Four, I believe.

A Health and Welfare-- medical services or Health and Welfare somewhere in Ottawa made arrangements with a number of universities about three or four years ago including Alberta, Manitoba, Toronto and I think Western Ontario to provide nurse practitioner courses which are largely

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devoted to the improvement of clinical skills and these courses have been operating continuously and are now still operating I think, Dr. Schaefer may know better than I, but I think it's been three university medical centers in the country now including Alberta, Manitoba and Western Ontario, for which I think there are probably I would guess maybe, it's a sheer guess, maybe fifty nurses, nurse practitioners who undergo that kind of training per year.

WITNESS SCHAEFER: One in French, in Sherbrooke.

Q Right. Now, are these outpost nurses, are those the ones you are referring to when you say nurse practitioner?

WITNESS HILDES: Yes, they are registered nurses who are in the position of providing primary care.

Q But are they specifically trained for this?

A Well, no. There's no particular degree. I think the only--I'm not saying and I don't want to be misconstrued about this that Health and Welfare do not put nurses into those positions only after they have had the courses I'm referring to. Most of the people, I think it was their policy as a matter of fact that was laid down originally, but they would prefer to have nurses have an experience of the field under supervision of other more senior nurses for some time before they

Hildes, Mayhall, Schaefer,
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Cross-Exam by MacQuarrie

1
2 take the nurse practitioner upgrading course so that
3 the people we get in Manitoba, four at a time, three
4 or four courses a year are either from the nurses
5 who have been in the Keewatin nursing stations or
6 in Northern Manitoba nursing stations and have had
7 experience before they come on the course.

8 Q I see. In the past
9 it had been the policy of National Health and Welfare
10 to employ registered nurses who had had special
11 training in public health or British or Australian
12 midwives. Is this still the current practice?

13 WITNESS SCHAEFER: Perhaps
14 it is more fair to Dr. Hildes, who, after all, is
15 mainly a representative of the province of
16 Manitoba and that I should try to answer that question.
17 We had instructions recently to employ Canadian
18 nurses, give preference to Canadian nurses and there
19 is such a ^{weight} put on that point that it has become
20 that the employment ^{rate} of those British, Australian and
21 New Zealanders has drastically been dropped.

22 We try to make up for that.
23 That is, our Department tries to make up for that
24 by providing some extra midwife courses to Canadian
25 nurses who normally don't have that.

26 Q Thank you.' What I would
27 like to know then is whether or not the nurses who
28 are working in the Territories are well enough
29 prepared to diagnose and treat the various conditions
30 that come to their attention in a settlement?

Hildes, Mayhall, Schaefer,
Cass, Noble
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WITNESS HILDES: " Well, I

think that's a very pertinent question and a very
difficult question. There is a varied ability among
the nurse practitioners and my own personal creed
or belief in this area is that the use of nurse
practitioners requires that they be provided with
regular, good back-up services and we try and provide
this by regular visiting, by the Health and Welfare
tries and provides it by regular conferences, up-
grading courses and we have--now that the communi-
cations has increased, has improved remarkably, it
has made our life a lot easier in the fact that we
can provide good back-up and advice and help when
they're facing very difficult decisions sometimes
about whether to request an emergency evacuation
or not.

I think, although as Dr.
Schaefer says, I can't speak for his Department and
I've been told that many times, I can at least
stand aside from the Department and say that the
Department from where I sit is very generous in
allowing the nurses to make decisions, to evacuate
when they are concerned about a patient, particularly
if they can't talk to a doctor about it.

Noble, Cass, Hildes
Mayhall, Schaefer
Cross-Exam by MacQuarrie

1
2 Q Yes, is it possible
3 though that cases that are not critical enough for
4 evacuation could likely be mis-diagnosed?

5 A I think that's a little
6 unlikely, particularly as we have a pretty regular
7 good backup service so that the nurse, any questions
8 she may have, refers patients to the visiting doctor.

9 Now, in some areas
10 such as middle ear disease where although the nurses are
11 generally pretty experienced in looking in ears, the
12 visiting consultant in ears may actually do school
13 surveys in order to pick up on the possibility that
14 some patients don't present themselves.

15 Q Having this tremendous --
16 the nurse having this tremendous responsibility that she
17 may not have been totally prepared for, the responsibility
18 of diagnosing and treating, may cause additional pressures
19 to her work load besides the fact that in many cases the
20 nursing stations are understaffed? For instance, Baker
21 Lake has always been seen on paper as a three-nurse
22 nursing station and it has been very seldom that they
23 have had enough staff -- two nurses if they are lucky and
24 more generally one. Has this kind of a situation
25 improved? You mentioned in your paper that the turnover
26 of nursing staff is very high.

27 A I don't -- well, I said
28 I thought that the turnover of nurses may be more rapid
29 now than it was a few years ago. With regard to Baker
30 Lake, let me just say that I think now that there is no

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1 real shortage of nurses in Canada, although there may
2 be shortage of nurses who are, who wish to "undertake
3 the tremendous responsibility you have mentioned.

4 In terms of Baker Lake
5 I think that at one time, although it was listed as a
6 three-nurse station, the two nurses who were there for
7 about three years felt very comfortable in running that
8 station by themselves and they requested that they be
9 allowed to do it. This is my understanding from talking
10 to the zone director at the time, so I am not saying
11 that there hasn't been difficulties with recruitment
12 and I think there still may be difficulties with
13 recruitment but I think largely in the Keewatin, the
14 complement of nurses is not -- is pretty good at the
15 present time. I don't know it is in the rest of
16 the Territories.

17 Q Even in Eskimo Point?

18 A There are three nurses
19 in Eskimo Point. Last week there were anyway.

20 Q Well, maybe this week.
21 Have you noticed any increase in the incidence of
22 emotional disturbances or violence, you know, injuries
23 due to violence as a result of the exploration that is
24 going on in the Keewatin now?

25 A I don't know that I can
26 comment on that because I think the -- I'm not quite
27 sure what particular exploration you are referring to.
28 There is always some sort of mining, exploration going
29 on but it seems to me that increasingly year by year
30 there are more ^{and more} people around and whether that is --

Noble, Cass, Hildes
Mayhall, Schaefer
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1 and as I indicated, I think that in my personal
2 opinion which is not particularly well-documented, there
3 seems to be an increasing prevalence of violence --
4 injury from violence, and deaths from violence. That
5 includes drowning and many of it as Dr. Schaefer has
6 pointed out, many of it is alcohol-related.

7 So if you're asking me,
8 do I think that the increase is due to the increased
9 exploration going on in the Keewatin, I can't answer
10 that.

11 THE COMMISSIONER: Well, that's
12 what she was asking.

13 MRS. MACQUARRIE: Yes. You
14 mentioned that the communications network has improved
15 greatly. Are there any communities there that still
16 cannot contact Churchill because of weather conditions?

17 A Yes, ma'am and I think
18 that there are three communities still -- Repulse Bay,
19 Whale Cove and Chesterfield that still have to rely on
20 the radio and unfortunately with the development of the
21 satellite, the actual radio services have deteriorated
22 so that now they have to go from say Repulse Bay to
23 Frobisher to Quebec to Ottawa to Winnipeg and back
24 to Churchill. I think that in my opinion it would be
25 an exceedingly high medical priority or health priority
26 to have satellite stations in all those places where
27 there are nursing stations.

28 Q Also weather conditions
29 often interfere with the evacuation of the medical
30 patients to the south? Or has this been --

Noble, Cass, Hildes
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Cross-Exam by MacQuarrie

1 A I suspect that the
2 Keewatin may have just as good flying conditions
3 as anywhere in the Arctic and when I look at the
4 Northwest Territories and compare it, to what I saw
5 in Labrador three years ago I think the Northwest
6 Territories is very well off.

7 Q In spite of the white-
8 out conditions that are prevalent in many winters?

9 A I think occasionally
10 and there have been occasional tragedies resulting from
11 inability to transport people but I don't know what
12 we can do about that.

13 Q The nearest doctor
14 is still -- for the Keewatin, is still in Churchill,
15 is that right?

16 A Yes, our doctors are --
17 for the -- well, I should elaborate on that. At
18 the present time, for the past ten months, the doctors
19 the general practice doctors that are visiting the
20 Keewatin are based in Churchill. The consultants that
21 are visiting the Keewatin are based in Winnipeg.

22 Prior to that, for the
23 previous two years, medical services had their own
24 field medical officer who visited the Keewatin. He
25 actually lived in Rankin Inlet which meant that he
26 sometimes had to come to Churchill in order to go to
27 the other places in the Keewatin.

28 Previous to that,
29 we were doing the visiting from Churchill again and
30 prior to that this is now going back to ten years ago,

Noble, Cass, Hildes
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1 or up to eight years ago, the medical services had
2 doctors, a doctor who was resident in Churchill and
3 who visited the settlements.

4 Q Yes, I wondered if any-
5 thing has been done regarding the ability of the
6 doctor who was in charge of the north to practice at
7 the Churchill Hospital. Oftentimes in the past, the
8 doctor serving the north would transfer his patient
9 to the care of a Churchill doctor who had no knowledge
10 of the case. The patient had developed a confidence
11 in the northern doctor but would no longer be under
12 his care once he entered Manitoba.

13 A It is largely for --
14 no, I don't think it was a question of legal jurisdic-
15 tions but it was on this sort of basis that we felt
16 it would much improve the continuity of care to have
17 the same doctors visiting the settlement as looking
18 after patients when they were evacuated to Churchill.
19 It was for those reasons that we a year ago or so
20 urged Medical Services to allow us to resume the
21 visiting in the Keewatin.

22 Q So now the doctor who
23 sees the patient in the community also treats him at
24 the hospital in Churchill?

25 A That's our intention
26 but, you know, if a person is visiting then he is not
27 in Churchill so that we attempt to identify one
28 of two doctors of the group in Churchill say, one who
29 takes a special interest in Eskimo Point; one who takes
30 a special interest in Baker Lake. On the other hand,

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1 he can't always be treating that patient. It depends
2 on who is on call but that's our intention, is to
3 provide the continuity of care in that way.
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Hildes, Mayhall, Schaefer
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Q Is "it not rather traumatic for the patient to discover that the person he thought was his family doctor in the north isn't able to take care of him when he's transferred out for further treatment?

A Well, I guess I could say you'd have to ask the patients, but in fact the nurse practitioners are the primary care people in the settlements. The physician that visits from Churchill comes for two or three days on a monthly basis, and I think that most of the people who attend the nursing station do not identify that visiting doctor, most of them don't even know him. He is largely there to back up the nurse and see the patients that the nurses want him to see. I think that they are happy enough to see a friendly face. When I see someone in Churchill Hospital that I have seen before, we usually exchange smiles and I think that they appreciate the fact that they know a familiar face. But I'm not so sure that -- well, I'm sure that the people in the Keewatin, because of the fact that a nurse practitioner is their deliverer of primary care, do not identify with the doctor in Churchill the way you do with your family doctor.

Q As an ex-resident of the Keewatin, sir, then --

A I'd be interested to know whether you disagree with what I said, as an ex-resident of the Keewatin. Maybe you can tell me

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by MacQuarrie

1
2 differently.

3 Q I disagree very much.

4 Also too --

5 MR. SCOTT: In Toronto
6 we don't have family doctors any more, I'm fascinated
7 to hear that they exist in these remote parts of the
8 country.

9 MRS. MacQUARRIE: No, it was
10 just that it was a tremendous shock to realize that
11 the northern doctor that you knew of, at least by
12 reputation, and had developed a bit of confidence
13 in, and saw you initially at the nursing station
14 was not -- although he accompanied the medical
15 evacuation to Churchill -- was not in fact continuing
16 with the care once you reached that community.

17 A Was this within the
18 last few years?

19 Q It was '70, and I just
20 wondered if that had changed, because I know that
21 many others, the native people as well, felt the
22 same way.

23 A Well, Mr. Commissioner,
24 I don't know if we want to pursue this, but it
25 depends in 1970 when it was because the University of
26 Manitoba Medical Unit officially assumed responsibility
27 for care in Churchill and visiting in the Keewatin
28 on the 1st of July, 1970.

29 Q It was May, 1970.
Getting back to your paper, I'm sorry about that,

Hildes, Mayhall, Schaefer
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on page 6 when you -- No. 7 -- when you outline the acute infections you didn't mention infectious hepatitis, and I wondered why this was not included.

A Just because I didn't think of it. I think infectious hepatitis, I wouldn't say the first cases but infectious hepatitis in large number has been a problem in the Keewatin, starting, I think, about 2½ years ago or three years ago. How it was introduced I'm not quite sure. We first began to see cases in Coral Harbour, and there may have been -- or in Repulse Bay, and it may have come down from the Baffin zone, we don't know. But since that time, infectious hepatitis has been a very significant problem in the Keewatin, as it is in many other parts of the country.

WITNESS SCHAEFER: If I may break in this one little piece of information, and I think we might like your welcome interest very much in it. Hepatitis, as Dr. Hildes has said, swept the Canadian Arctic particularly in the eastern and central Arctic, quite dramatically coming from Greenland, then Northern Baffin Island, all Baffin Island, via Repulse Bay into the Keewatin, in a typical epidemical form, as Dr. Hildes said, two to three years ago. There was less recent research has shown that there maybe both in Greenland and in Baffin Island and perhaps in the rest of the Arctic, a form of hepatitis, so-called the B type, epidemic and we need to do a little bit more research -- not perhaps

Hildes, Mayhall, Schaefer
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1
2 you in your influential position here in Yellowknife,
3 plus the -- our native listeners here, may perhaps
4 show more patience because right now we're on a band
5 wagon against more research. Sometimes research is
6 very important to clarify issues and to help people.
7 This is a very important thing to find out, what type
8 of hepatitis we do have, in endemic and epidemic form
9 in the Arctic, and sometimes we have to take blood
10 samples. There is a justified resistance against
11 more research in some population groups, but sometimes
12 we have to be patient and understandable on both
13 sides to see the reason for it. I am finished with my
14 plug.

15 Q Mr. Commissioner, I have
16 a number of other questions but it is late.

17 MR. SCOTT: Is the Commissioner
18 chewing his belt.

19 MR. BAYLY: How is your vitamin "C" supply?
20 THE COMMISSIONER: I've got

21 enough to go for awhile.

22 MR. BAYLY: I would like, if
23 possible, to allow these witnesses to leave early
24 tomorrow and I don't know how you feel about sitting
25 tonight, sir. That's a possibility I would at
26 least ask you to entertain it.

27 THE COMMISSIONER: Well, I
28 think, Mrs. MacQuarrie, that we should try to
29 accommodate these witnesses so they can get their
30 morning plane because they're all busy and have
important responsibilities for the health of this part

Hildes, Mayhall, Schaefer
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Cross-Exam by MacQuarrie

of the country, and they were here yesterday. Well,
I don't mind coming back this evening. What do you
think, Mr. Scott?

MR. SCOTT: What time is the
morning plane, Mr. Bayly?

WITNESS HILDES: Well, Mr.
Commissioner, I don't like to influence the hearings
in this way, but if everybody is happy to stay on
for another half-hour or hour, we might catch a
plane this evening, which would be even better for
us. But if you wish us to have a session tonight,
I think the morning plane tomorrow is at, leaving
here is at 10:45.

THE COMMISSIONER: Yes.
Well, I don't mind staying for a while, Mrs. Mac-
Quarrie, for an hour or so. I know you must be
getting tired.

MRS. MacQUARRIE: I just
have a few more but I don't know if the others
have.

THE COMMISSIONER : Well,
how long do you think you'll be, Mr. Steeves?
Mr. McDougal? I see fresh reinforcements have just
been brought in.

MR. HOLLINGWORTH: We don't
have any questions.

MR. SCOTT: I'll be 20
minutes, but I'd be prepared to outline my questions
to the panel and ask them to write me about them.

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by MacQuarrie

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2 I hope my questions will require them to think a
3 little bit about needs.

4 THE COMMISSIONER: Well, why
5 don't you carry on, Mrs. MacQuarrie, and we'll just
6 see how far we get? This hockey game can begin without
7 us, I think. Is that all right?

8 MRS. MacQUARRIE : It may not
9 be good for your mental health, but I'll be quick.

10 Q In 1968 I believe, there
11 was a number of cases of hepatitis at the Churchill
12 Hospital among the staff. Was this a different strain
13 than the one that came to the Keewatin through -- from
14 the Baffin region and Greenland?

15 WITNESS HILDES: I don't know
16 if Dr. Schaefer knows the answer to that. I certainly
17 don't. I think the distinction -- well, I do know the
18 answer to that because in 1968 there were no methods
19 of clearly identifying strain A hepatitis from strain
20 B hepatitis. That has only happened in the last four
21 or five years with the identification of a strain of
22 antigen so that the question cannot be answered
23 specifically. It could be guessed at epidemiologically
24 but I have no knowledge of those cases.

25 Q I asked that because
26 there were a number of isolated cases in the Keewatin
27 at that time which we thought had come up from
28 Churchill. Going onto your mention of meningitis,
29 also too this seems to be an annual occurrence in the
30 Keewatin.

Hildes, Mayhall, Schaefer,
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Cross-Exam by MacQuarrie

1
2 A I don't know about
3 annual occurrences. It's been bothering us that
4 there is what seems to be more bacterial meningitis
5 we're talking about now. I think that there are
6 a number of kinds of meningitis but we're talking
7 about bacterial meningitis.

8 It seems to be perhaps
9 of some increased prevalence and just as part of the
10 general infectious pressure, I think that Dr.
11 Schaefer and others were so concerned about it
12 that in 1969 we made a special survey of Baker Lake
13 because of the concern then. What we came up with
14 then was that there were carriers of certain
15 bacteria in the throat at a fairly high prevalence,
16 not too dissimilar than what one finds in southern
17 communities but we also found different strains
18 and different antibiotic sensitivities.

19 So, bacterial meningitis
20 has been an ongoing problem. I don't know what
21 else to say about it.

22 Q Is it higher in the
23 North than it is in other parts of Canada?

24 A I think so but that's
25 an impression which is my clinical impression.

26 Q I believe at that
27 time the community was placed on--everyone in the
28 community was placed on antibiotics for two weeks
29 and it seemed to me that in the communities in the
30 Keewatin, not only at that time but often now, many

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by MacQuarrie

1
2 of the residents receive a series of antibiotics in
3 case of--well, as a prevention. Is that still the
4 practice?

5 A That particular
6 application of antibiotics was decided on after we
7 had surveyed the throat swabs and taken blood samples
8 from most of that population and we had a conference
9 and decided that we, although we didn't really expect
10 too much from it, and having studied the sensitivity,
11 that we would like to try and reduce the carrier
12 rate by a total application for, I think, it was
13 four days of antibiotics at that time.

14 I think our subsequent
15 findings, if I can recall rightly, is that it did
16 reduce the carrier rate but within six months, the
17 carrier rate was back where it was.

18 Q I see. On page eleven,
19 I think it is, the B section of number four, you
20 mention that the communities are making many demands
21 and criticisms. Are these, in your opinion, without
22 justification?

23 A No. That's not so.
24 I think that in many cases people are frustrated with
25 the system and would like to operate--would like to
26 have more of a say in the system and this is one
27 way of expressing their frustration and concern as
28 by picking on something within the system that they
29 don't like. I'm not saying that they're frivolous.
30 I'm saying that sometimes they're unrealistic.

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by MacQuarrie

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2 Q But it appears that
3 these requests or perhaps demands, whichever way you
4 would interpret it, are merely the request for
5 health services that are enjoyed by any Canadians
6 in Canada.

7 A Well, I'm not quite
8 sure which ones of those that I have listed you are
9 referring to.

10 Q Pardon?

11 A If you're referring
12 to the availability of a doctor, the right to see
13 a doctor, I think that is a right of all Canadians
14 and in terms of the residence of the Keewatin, it's
15 difficult to achieve that at short notice.

16 Theoretically they can
17 achieve that once a month during the visiting
18 physicians--during the visiting physicians visit or
19 they can achieve that by going to the nearest
20 medical center. Now, as a substitute for that, all
21 across the Arctic, the development of nurse--the
22 program of nurse practitioners.

23 I'm not defending that in
24 any sense but I'm saying that right at the present
25 time it's only realism to recognize the fact that
26 there is no resident doctor in Whale Cove and it is
27 unlikely that there will be a resident doctor in
28 Whale Cove for a very long time to come.

29 Q And the larger
30 communities do not have resident physicians either

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by MacQuarrie

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2 but apparently there is not even a nurse on call.
3 What do the people do after hours when a medical
4 crisis occurs in the night?

5 A I think in all the
6 settlements, including those where there is only a
7 single nurse, the nurse is on call but she may be
8 on call in her own quarters which is down the hall
9 and not actually in the clinic.

10 I don't know. I don't
11 know what the policy is of Health and Welfare
12 and I don't care about the niceties of the situation.
13 I think in all those settlements, the nurse is
14 available. Now, one can't always answer for the
15 nurse. She may be tired. She may not be perfectly
16 polite on every occasion at two o'clock in the
17 morning.

18 But the nurse is on call.

19 WITNESS NOBLE: Joe, I wondered if I
20 could just make an addition to that? I've been in
21 quite a few of the settlement nursing stations and
22 overnight in the North delta and there's been an
23 increasing problem. I don't want to name the
24 communities but shall we say ones that have been
25 exposed to access by roads and a lot of changes going
26 on, increasing number of drunks showing up at all
27 hours of the night.

28 In one nursing station that
29 I was at--I had to take a friend of mine at 2:00 A.M.
30 in the morning and I met the nurse and she'd been

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by MacQuarrie

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2 called out already four times to homes in which there
3 was drunken fighting going on. Some of the nursing
4 stations, you know, nurses are really afraid to step
5 out and in this once particular community, a person
6 just burst in the nursing station and smashed the
7 nurse in the face.

8 I think that we're seeing,
9 at least in our area, an increasing number, you know,
10 of social dislocations; behavioural problems that
11 end up on the nurses step because there isn't any
12 other place in town for them to go. You know, the
13 social development officer doesn't work after hours
14 unless called to by his supervisor.

15 Q Yes, I realize that the
16 pressures on the nurse in the station are tremendous.
17 In many cases they are working very long hours and
18 then are expected to be on call. Is the Department
19 doing anything to perhaps alleviate this situation
20 for her?

21 WITNESS HILDES: Put that
22 question to the member of the Department here.

23 WITNESS SCHAEFER: Although
24 I was not sent by my Department here, but they also
25 didn't hinder me to appear for COPE here, I still
26 have worked for them for twenty-four years, so I
27 think I should answer that.

28 The Department--I am actually
29 very happy about many of the critical remarks made
30 by Gaile Noble, for example. The report by George

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by MacQuarrie

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2 Wenzel. I'm quite happy. I don't agree with all the
3 points and I could in certain details actually
4 contradict them but the general tone I'm very happy
5 about. It helps us to build up ammunition to get
6 a little bit bigger share of the pie. What we must
7 realize in a time when government is called upon to
8 exercise austerity, we are cut down in size.

9 All I'm fighting now for
10 is that the Health Department isn't too much cut
11 down but there are limits to everything. I think
12 we have to be realistic. There are limits. I see
13 black and that was my warning in my own paper for
14 the future if we are already in trouble and can't
15 fulfill right now, what will we do then?

16 Q Thank you. Both--

17 WITNESS HILDES: Excuse
18 me. I wasn't being frivolous when I said that I would--
19 the way you phrased that question, it really could
20 only be answered by someone who has a direct line
21 responsibility to Health and Welfare and I do not
22 have and that's very clear and Health and Welfare has
23 told me that many times.

24 But in fact, I think that the
25 fear that I've expressed in this paper, this
26 presentation is the fact that there are 'increasing
27 demands, there will be more increasing demands with
28 all development and we should try and be prepared for
29 that and the Department should try as hard as possible
30 to foresee the demands and be prepared for it.

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by MacQuarrie

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2 Now, some of these may be
3 very difficult because if we're going to have a
4 situation in which we may have to have some security
5 for the nurses against attack in the middle of the
6 night. It creates a very great problem of the
7 relationship between that nurse and the community.

8 So, one of the reasons I
9 think why nurses do not like to sit in the nursing
10 station by themselves but would sooner be down the
11 hall in their own quarters is for that reason of
12 security and there is no question that nurses have
13 been assaulted in the middle of the night by people
14 who don't like the nurses for one reason or another
15 or maybe under the influence of alcohol.
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THE LIT.
BURNABY 2, B.C.

Noble, Cass, Haldes,
Mayhall, Schaefer
Cross-Exam by MacQuarrie

Q Does the
R.C.M.P.'s plan to cut back on the support service they
have supplied to the nurses in the nursing station alarm
your department at all? In that, I believe, they will
withdraw the escort service of mentally ill to the South
and this kind of thing.

WITNESS SCHAEFER: I must
apologize not being familiar with the newest policy
on that, but I think there was an agreement with Social
Service that they would certainly take over transportation
back of patients from hospital. I do not know now
how the escorting -- on whom falls the duty of escorting
patients out. I think this is still essentially our duty.
In fact, I think we certainly do accompany sick patients,
let say, evacuate for pneumonia out. For the mentally
ill I think the same would apply.

Q Yes, they have --
the R.C.M.P. have provided this service to the Nursing
Stations in the past but I understood that at the last
Territorial Council session there was a plan for the
R.C.M.P. to cut back on many of the support services
they had afforded and I wondered if your department is
making plans to fill in the gap there.

A I cannot answer this
question. My apology. I am, unfortunately, that close
to the administration right now.

Q Again Dr. Hildes and
Miss Noble have talked, Miss Noble about the necessity to
have formed in the communities advisory committees. You
say that you have such an advisory committee in some of

Noble, Cass, Hildes,
Mayhall, Schaefer
Cross-Exam by MacQuarrie

1 communities in the Keewatin. Is that so Dr. Hildes?

2 WITNESS HILDES: I don't
3 speak with authority on this but there are health ad-
4 visory committees I think in all the Keewatin settlements
5 or if they're not there they're in the process of being
6 formed.

7 Q On page 12 of your
8 testimony you say that political and cultural new bodies
9 will come into conflict with the bureaucratic operation
10 of health services. Is that a foregone conclusion?
11 Do they not work well together at a -- is there not a
12 degree of co-operation that could be met?

13 A I think what I said is
14 that the new political bodies will likely come into con-
15 flict with a bureaucratic operation if it remains bureau-
16 cratic. That's what my intention was. I don't think
17 that's a supposition, I think it's already happening.
18 That -- we heard today and yesterday that COPE and I
19 know that there have been meetings of ITC, the Keewatin
20 Inuit Association, the Inuit Cultural Institute which as
21 well as the local hamlet councils, settlement councils
22 and health committees are all trying to, and rightly so,
23 in my opinion, trying to influence the health services
24 in order to make it less bureaucratic.

25 Q Do you seek any
26 possibility that perhaps they can attain a degree of
27 co-operation?

28 A Oh yes, I hope so.

29 Q Do you have any idea
30 what some of the solutions would be to maintain a level
of co-operation rather than conflict?

Noble, Cass, Hildes,
Mayhall, Schaefer
Cross-Exam by MacQuarrie

1 A Well I've indicated that
2 in my opinion there ought to be not only local committees
3 but since health and health delivery certainly has a
4 regional connotation, that there should be regional
5 advisory committees with the expectation, in my view,
6 that those -- that they should assume -- they should
7 evolve into a managerial role. Now, in this sense I
8 have fairly clear evidence that at the present time this
9 is not the policy of Health and Welfare because my
10 comments in these directions have been commented on by
11 senior officials in Health and Welfare to indicate to
12 me quite clearly that they do not see that evolution
13 going on certainly in the time frame I see it. So that
14 I'm giving my own opinion here and I can't rally speak
15 for the Department but I do hope that the residents
16 of the Northwest Territories will be able like all other
17 Canadians to have a hand in their own affairs in this way.

18 Q Could you comment, Dr.
19 Schaefer?

20 WITNESS SCHAEFER: Yes, I'm
21 quite happy to comment. I subscribe ^a hundred percent to
22 the demand or proposal by Dr. Hildes, that there should
23 be greater consumer involvement in the health care delivery
24 policy and planning. I do agree ^a hundred percent even if
25 not all members of my department agree. And I hope that
26 more and more people in my department are coming around
27 to agree to that too. And if they don't do so, they will
28 be left behind. I also subscribe to a number of other
29 points made by Dr. Hildes in his paper but you may like
30 to come to that yourself.

Noble, Cass, Hildes,
Mayhall, Schaefer
Cross-Exam by MacQuarrie

1 Q Well, go ahead, if
2 you like.

3 A Well I do even believe
4 in what he made -- Dr. Hildes made a proposal that there
5 should perhaps be a independent audit system. And he
6 pointed to the fact that they operations of Department
7 of Health and Welfare are not audited from an independent
8 source. Involving such huge amounts, not only of money,
9 but other things which are of more worth than money. I
10 believe that this would not -- would really help and not
11 hurt both equality of care delivered as well as allaying
12 increasing distrust of often unwarranted and undeserved
13 distrust which we now encounter in different quarters
14 and actually elucidate some of the sources of even
15 irrational criticism. Some examples were even cited
16 in some of the examples: today. I believe, therefore,
17 fully in both proposals of Dr. Hildes. But I know that
18 I at odds with some other members of my department.

19 THE COMMISSIONER; Excuse me,
20 Mrs. MacQuarrie. Dr. Schaefer, ^{it} just occurs to me, are
21 you on COPE's panel on alcoholism by any chance? No.
22 You have pronounced views, don't you, on alcoholism?
23 Didn't I read a paper of yours?

24 A Yes.

25 Q This is by the by but
26 just before Dr. Schaefer leaves and it slips my mind.
27 You urged that prohibition throughout the Northwest
28 Territories, didn't you?

29 A I didn't word it that
30 way, sir. I did word in the way that if a majority of

Noble, Cass, Hildes,
Mayhall, Schaefer
Cross-Exam by MacQuarrie

1 people on a local level feels that that desparate move
2 is the only straw what will help them, we have not right
3 to prevent to clamp on that lock. Even if I would be
4 convinced it was ^{/a wrong} procedure, I believe it is an absolute
5 wrong doing by coming in and saying the law of the land
6 is different if that group may feel that is the
7 salvation for them.

8 A few years ago, as a matter
9 of fact, in this town a had a discussion with territorial
10 government authorities on it in a public discussion about
11 alcoholic abuse and drug abuse at the meeting -- a cross-
12 Canada meeting here in this town. And Territorial
13 Government officials notified me that this was against
14 the law of the land and therefore nothing -- I shouldn't
15 even discuss it. I feel if the law of the and is
16 different the law of the land has to be changed because
17 the law is for the people and the people for the law.

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Hildes, Mayhall, Schaefer
C ass, Noble
Cross-Exam by MacQuarrie

Q Well putting that aspect of it to one side, the -- one of the things that you've dealt with in your evidence this morning was what you felt was a likely increase that would occur if a pipeline ^{and} related development came to the Northwest Territories. You dealt with what you felt was the likely increase that would occur --

A Yes.

Q -- in violence related to the use of alcohol, and in the measures you propose ^{the situation} to ameliorate, and you didn't refer to any limitations on the importation or purchase of alcohol. Well, we have in the Northwest Territories now a kind of local option that is in force in apparently Frobisher Bay and Fort Rae, to name two places, the local option was not to. That's the kind of prohibition you had in mind, or did you have in mind prohibition applying to the whole Northwest Territories?

A No sir, I had in mind what you just interpreted. I'm very happy, indeed I was very happy to see the change in the minds of some Territorial as well as other authorities on that question. As a matter of fact, ^{me} some of the same authorities who contradicted in '67, did go ahead and worked on changing the laws so this was possible, and I am very happy that this thing happened. This points out some of the fears of our native population. If they have not a chance to influence their own laws, their own prohibitions, being swamped into a minority

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by MacQuarrie

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2 such a measure which they felt was necessary for
3 Rae-Edzo, they wouldn't have a chance in life to
4 enact right now in INuvik even if they wanted it.

5 THE COMMISSIONER: Yes.

6 MRS. MACQUARRIE: I just have
7 two more questions.

8 Q Dr. Hildes, do you meet
9 regularly with the other Federal Government health
10 people who deliver health services to the Territories?

11 WITNESS HILDES: I'm sorry
12 you'll have to say that again because I heard something
13 paradoxical. Do I meet regularly with the other Federal
14 Health people?

15 Q Yes, who deliver health
16 services to the Territories.

17 A Well, I don't understand
18 the question.

19 Q Well --

20 A Because I'm not a
21 federal authority. I'm a University of Manitoba.
22 Do you mean do I meet regularly with my counterparts
23 in Alberta --

24 Q -- that's right.

25 A -- and -- no, I think
26 it would be very useful if we did. But there is no
27 organization or resources for that. I have suggested
28 that to the regional director of the Northwest
29 Territories, not the present regional director but
30 his predecessors, that there be some regular interchange

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by MacQuarrie

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2 between the various universities involved, and the
3 various consultant groups involved at the administra-
4 tive level, the overall level, and at/ ^{each} disciplinary
5 level; but we have -- that's failed to materialize
6 except in a very limited way. I think that there has
7 been, at the instigation of Dr. Gordon Butler some
8 years ago, a group of people who were involved in,
9 psychiatrists and Mr. Kehoe who were involved in
10 mental health delivery, to tour the Arctic and produce
11 that report, which is dated way back in '69, I guess.
12 There was, I think, some concerted action in eyes
13 and I think that Professor Grants or Professor
14 Sam Adams ^{perhaps} from McGill, Dr. Cass knows better than I,
15 did under the aegis of Dr. Gordon Butler, conduct
16 a survey of opthalmic conditions across the
17 Arctic. There was a couple of years ago a meeting
18 in Edmonton of a number of the ear, nose and throat
19 people, consultants who were involved, but to my
20 knowledge that's the extent of that sort of operation
21 now. I do occasionally in airports meet with
22 Professor Harry Bain from Toronto, and other people
23 of that sort; but we have no regular route of
24 communication.

25 Q I see, so this lack of
26 communication would account for the somewhat fragmented
27 health service delivery in the Northwest Territories
28 then?

29 A Well, that's an
30 interesting question. I wouldn't subscribe to that

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by MacQuarrie

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2 in the sense that I don't know whether the service
3 is fragmentary, I would agree to that or not.
4 I think there is some sort of a policy. I think there
5 is unevenness across the north, and I think the
6 arrangements made by the regional director with
7 various universities differ, and I think that it
8 would be good, the suggestion that you have implied,
9 that there be regular meetings of the support groups
10 in order to exchange ideas and in order to have a
11 uniform service across the area would be good. I
12 don't know whether the service is fragmentary or
13 not.

14 Q I meant in using that
15 word that health service delivery is
16 different for the Western Arctic than it is
17 for the Keewatin and the Baffin region.

18 A The conditions are
19 different. Churchill is the only secondary care
20 institution at the present time that is not within
21 the Territory, and the other two major ones at
22 Inuvik and Frobisher are owned and operated by
23 Health & Welfare, so that there are geographic
24 differences in addition to administrative differences.

25 Q Are you familiar with
26 the Northwest Territories Health Co-Ordinating
27 Council?

28 A No, I'm not.

29 Q Dr. Schaefer, are you?

30 WITNESS SCHAEFER: No, sorry.

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by MacQuarrie

1
2 MRS. MACQUARRIE: Those are
3 all the questions I have.

4 THE COMMISSIONER: Fine, thank
5 you, Mrs. MacQuarrie. Mr. Steeves, do you have any
6 questions?

7 MR. STEEVES: I have no
8 questions.

9 THE COMMISSIONER : Mr.
10 Hollingworth?

11 MR. HOLLINGWORTH: No questions.

12 (PROCEEDINGS ADJOURNED FOR A FEW MINUTES)
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Noble, Cass, Hildes
Mayhall, Schaefer
Cross-Exam by Scott

1 (PROCEEDINGS RESUMED PURSUANT TO ADJOURNMENT)

2 THE COMMISSIONER: Let's
3 resume our places. Mr. Scott?

4 CROSS-EXAMINATION BY MR. SCOTT:

5 Q Mr. Commissioner, I
6 think I can be relatively short with my questions and
7 as I suggested, if any members of the panel consider
8 it preferable to do so and wish to defer any answer and
9 decide that they'd rather think about the matter and
10 write me or the Inquiry about it, I would be quite
11 content with that kind of a response.

12 I want to follow up
13 one question that Mrs. MacQuarrie asked when she asked
14 one member of the panel to comment on what he assessed
15 to be certain gaps in the provision of medical resources
16 in the Northwest Territories. I think Dr. Hildes
17 comment that he thought perhaps there was a gap in
18 juvenile clinical psychology, in alcohol programs in
19 the settlements and in general counselling and I would
20 like to ask each of you from your own experience and from
21 your own observations, are there other gaps that
22 presently exist in the provision of reasonable medical
23 resources in the Northwest Territories and if so, what
24 are they? Does anybody want to try that now?

25 WITNESS HILDES: I thought,
26 Mr. Commissioner, that the counsel was going to not
27 make that quite so broad and I was thinking in the Mental
28 Health field, that the provision of services for teenagers
29 it seems to me, to be a very extensive and important
30 area. This is the group that is most exposed to

Noble, Cass, Hildes
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Cross-Exam by Scott

1 cultural change and the differences between generations
2 and appears most lost in the whole situation. So
3 in terms of mental health, I think that, now, what
4 kind of facilities I'm a little beyond my depth but
5 I think the facilities for the teenagers and counselling
6 for teenagers in what they are going to do with their
7 lives, what sort of educational endeavours they should
8 have, what their problems are with alcohol or gas
9 sniffing or changing moralities and sex, I don't know.
10 But I think that's a gap in the mental health field
11 that I recognize as well.

12 Q Anybody else?

13 WITNESS MAYHALL: Well, I'll
14 respond to that from a dental standpoint. I can't
15 call myself an authority on the provision of dental
16 needs for the Northwest Territories at the moment
17 because the personnel, the level of personnel seems
18 to be a rapidly fluctuating phenomena. In some years
19 they seem to have a fair number of people available
20 to provide treatment. Other times, it's grossly
21 inadequate. But I think overall from the concerns that
22 I hear voiced from the people who I come in contact
23 with, not only experts, so-called experts in the south
24 but also from the individuals there is an overwhelming
25 demand at the moment and a continuing demand for
26 increased dental treatment and preventative services,
27 which seems to be unmet.

28 The reasons for this,
29 I think, there are several. I'm only speculating but
30 one of them seems to be the inability to attract

Noble, Cass, Hildes
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Cross-Exam by Scott

1 dental professionals to the area and when they are
2 attracted to keep them for a long time a problem of
3 knowing how to utilize them best and also the
4 institution of any kind of preventative treatment.
5 All these things are exacerbated by the fact that
6 we do not have any good records on the -- or indications
7 of what the needs of the people are in even rough
8 terms. All we know is that there is a tremendous
9 problem there which is not being met at the moment
10 and we have no firm good figures to indicate what
11 levels of personnel there be needed to treat.

12 Q Well, Dr. Mayhall,
13 in terms of the facilities and services and programs
14 that are available generally to southern Canadians
15 is that demand or request that you pinpointed a
16 reasonable one?

17 A Yes, I think it is.
18 You mean the demands of the northern people?

19 Q Yes.

20 A Yes. I think it is
21 reasonable to ask and require a higher level of care
22 than they're receiving at the moment. It seems to
23 me reasonable for them especially as far as dental
24 services go to expect a level of care somewhat
25 comparable to what might be available in some of the
26 rural areas of southern Canada if not the urban areas.

27 At the moment this
28 isn't possible from all the information I can gather.

29 Q Dr. Cass, do you want
30 to add something to the list?

Noble, Cass, Hildes
Mayhall, Schaefer
Cross-Exam by Scott

1 WITNESS CASS: Yes, I was
2 going to say, was Dr. Mayhall aware that there is a
3 School of Dental Therapy at Fort Smith?

4 WITNESS MAYHALL: Yes.

5 WITNESS CASS: There are
6 six dentists there. They have put dental therapists
7 in every place. I was up in Cambridge Bay recently
8 and they had one there who is working hard the whole
9 time and all the time the dentists are travelling --
10 one or other dentists are travelling around seeing
11 what work is being done and helping out with the
12 dental therapy. Dr. Lumb has recently come back from
13 a three-month tour where he has been going around the
14 Arctic. Dr. Lumb is a trained dentist who has been
15 visiting the dental therapists in the settlements and
16 also giving dental care.

17 Q Just let me make my
18 question clear. My question isn't intended to provoke
19 an answer that reflects on the ability or the earnestness
20 of the people who are already in the field. I'm not
21 concerned about that. I'm sure they're working as
22 hard and as full-out as they can. I'm simply asking
23 whether there is a need that you as professionals
24 think is not being reasonably met.

25 WITNESS MAYHALL: Well, I would
26 like to expand -- in answer to your query and in
27 replying to what Dr. Cass has said. I am aware of
28 the dental therapy program and it's too early yet to
29 evaluate what its longterm effects will be. There
30 seem to be some slight problems which I think will be

Noble, Cass, Hildes
Mayhall, Schaefer
Cross-Exam by Scott

1 overcome in the future. One of them has been the
2 problem of retaining native people in the program. It
3 is a rather long tedious program and initially the
4 people who began the program of the native people, a
5 very minimal number if any completed it, because of,
6 I think, a lot of it because of homesickness and many
7 other factors.

8 Another problem seems
9 to be the fact that at the rate they're turning out
10 people it's still going to be a long time before even
11 there will be a dental therapist or a dental nurse or
12 whatever you want to call them in most of these
13 communities.

14 I am not making a
15 plea necessarily for more dentists. I realize that
16 there are a lot of people in my profession who feel that
17 only dentists can provide dental care. I am not of that
18 conviction at all. I'm in favour of paraprofessional
19 personnel wherever possible but I must reiterate my
20 plea to have some idea of what our needs are before
21 we start trying to fulfill them. If we don't know what
22 they are, we can't -- we really don't know how to plan
23 in the future and we don't know.

24 Q Well, Dr. Cass, do
25 you think that there are any needs that you can pinpoint
26 at the present moment for which resources are not
27 available?

28 WITNESS CASS: Yes, I can tell
29 you this, that we're getting people educated at
30 A.V.T.C. and what Dr. Atcheson remarked yesterday is

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Noble, Cass, Hildes
Mayhall, Schaefer
Cross-Exam by Scott

1 perfectly true. They are having far too short a
2 course with the result that they cannot compete with
3 people who come from the south. Now, the dental
4 therapist school is quite apart from this and they are
5 having a two-year course which I believe is adequate
6 to dental therapists. But the other people -- the
7 ones that he mentioned, as Dr. Atcheson mentioned,
8 they have five-year course for clerk typing. They
9 haven't the education and they cannot compete with the
10 clerk typists who are better educated and the two
11 years training outside.

12
13 Now, another thing is
14 before they come down, quite often no examination is
15 done. There is supposed to be an examination. They
16 are not sufficient doctors -- or the doctors
17 aren't going to the settlements when these people are
18 here. Sometimes they've been out in the bush or out
19 on another temporary job and they do not get a proper
20 medical examination.

21 I know from the point
22 of view of eyes, I have had people come on their own.
23 They're not sent up to us now. They're not sent to
24 the doctor. They're not sent to me. I have had men --
25 very disappointed men -- they think they're failures and
26 I have found this muscle condition which I mentioned
27 to you in the eyes. There was man who was a carpenter,
28 an Eskimo from the east and just as he completed his --
29 he had been turned out of his course because he couldn't
30 hit the nail on the head. Well, if they had sent him
to me first I'd have told them that this man has no

Noble, Cass, Hildes
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Cross-Exam by Scott

1 binocular vision. His job as a carpenter is not
2 suitable for him. As it is that man has gone back
3 and he feels he is a failure and inferior and I think
4 before they have these courses, firstly they should
5 have full medical examinations and secondly I think
6 that it would also save the waste of money. They bring
7 people down from the settlement and if they have him
8 on a course which he half fulfills, it's just wasting
9 the country's money.

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by Scott

Q Dr. Schaefer now, I recognize that you work for a department for whom you're not speaking at the moment, and that the department operates on a limited budget; but if you were preparing a needs priority list, for the Northwest Territories, have you anything that you'd add to it, apart from what the other panelists have said?

WITNESS SCHAEFER: I think perhaps I made all these statements that I definitely feel that there's a greater need not to reduce expenditure in our department, but that our department particularly in their operations in the Northwest Territories, need a greatly expanded budget. We have heard here over and over again that there are positions not filled; that there is a greater need to do that, and we have to be realistic to direct people and keep them there you have to make it competitive. Some come really for the love and enthusiasm of it but many of them and most of them, perhaps most of them come also for financial benefits or at least that love and enthusiasm will wear off if they are really living financially better in the south. That goes for our nurses, for example. I also want to make a plug for, as I said before, greater native involvement even on the policy and planning level. I also and in that respect I was very interested in the remarks of Gaile Noble which she made about some native uneasiness about shifting from one bureaucracy the Ottawa-based bureaucracy to

Hildes, Mayhall, Schaefer
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Cross-Exam by Scott

the other bureaucracy based in Yellowknife, without properative input, and I emphatically identify with the Minister's statements which he read ^{here} into the record in a letter to Sam Raddi, that the transfer of responsibility must not happen until the Department is satisfied that the level of medical care will not suffer, that the know-how is available at the Yellowknife level to give that care and I would add to that, add to the Minister's statement and until an informed consent in the real sense of the word "informed consent" that the patient knows what the operation is about, or that the native groups know what is involved, and they give the consent to the transfer, then I'm all for it.

Q Thank you. Well, Dr. Hildes, for example, what do you say about Dr. Schaefer's statement on the prerequisites for a transfer of jurisdictions?

WITNESS HILDES: I don't really see that, personalities aside, that it makes much odds. There has to be some sort of agency which operates the health system. I think that the move which was taken a number of years ago to give depth to the medical services being provided by involving university groups was a good one. At the present time I have that arrangement with Health and Welfare. I don't -- we have disagreements often. I think that if the responsibility for the health care was transferred to the Northwest Territorial Government

Hildes, Mayhall, Schaefer
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Cross-Exam by Scott

1 and the Northwest Territorial Government also required
2 or requested help from the universities across the
3 country, I think it would be forthcoming in the
4 same sort of way. So I don't see any fundamental
5 difference in which bureaucracy operates the system,
6 except to agree with Dr. Schaefer that an informed
7 public ought to have a hand in making those decisions
8 and I would prefer to see them operating the system
9 within that bureaucracy. So I don't really have any
10 particular opinion about when that transfer happens,
11 if it happens, and how it happens. I think that Dr.
12 Schaefer is right about how it happens. I was told
13 many years ago that the whole system was a little
14 fragile and may be transferred in time. I don't feel
15 any -- I don't feel threatened in any way about that.
16 If it's a good system operating and the whole Terri-
17 tories can look after the whole business of health
18 care within the Territories, and they have all the
19 expertise they require within the Territories,
20 then God bless them. But if they don't have that and
21 they're going to operate the system, then they must
22 make provision for borrowing that. I have a feeling,
23 and I'm expressing a very personal opinion now, that
24 the Northwest Territorial Government is a little
25 parochial, they like to have everything within the
26 Territories and I think in health^{care} delivery that is
27 quite unrealistic at the present time.

28 Q Dr. Schaefer you, in
29 answering my question, pin-pointed the necessity of
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Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by Scott

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2 having adequate funds to attract personnel and the
3 necessity of getting appropriate native input into
4 policy and other like decisions, but you didn't have
5 the budget constraints that seem to be inevitable have
6 you any programs that you would -- to which you would
7 attach priority, apart from those?

8 WITNESS SCHAEFER: I believe
9 Dr. Hildes zeroed in on one which I also would have
10 named as my first priority, that is the adolescent
11 group which is most endangered -- you heard that yester-
12 day in the mental health panel -- which on the other
13 hand is easiest, not easiest, I made there a mistake,
14 but where there is greatest hope to be influenced, and
15 has the greatest necessity to be influenced to zero in
16 on a number of ^{programs for} adolescents. This could be in the
17 sense of greater psychological services being available
18 to them, greater educational involvement, greater
19 recreational involvement. This goes really marginal
20 areas which are not any more strictly medical but
21 partly social.

22 Q Are there any other
23 programs to which you'd attach a significant priority
24 for the future?

25 THE COMMISSIONER: I think
26 Dr. Cass said something.

27 WITNESS CASS: Yes, I'd like
28 to go into the question of diet, how to obtain the
29 best food and also to ^{encourage} people to grow their
30 own produce here. They had a farm in the old days in

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by Scott

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2 Fort Simpson that gave us excellent food. I think we
3 ought to have analysis of the soil to improve the
4 soil, if necessary. I know we're short again of
5 calcium at Fort Smith. Most people have gardens and
6 we do get natural produce. I think also I would like
7 to see a program like the Russians and the Japanese
8 have been doing in finding out the causes, exactly which
9 type of myopia it is. I think we ought to have measure-
10 ments of the eyes taking place and I think it ought
11 to be treated as it is in other countries. There is
12 somebody in Toronto who is treating it now.

13 Q Dr. Hildes, you --

14 WITNESS HILDES: Well, I was re-
15 thinking I've already said it and it's perhaps not
16 the time to be reiterating, and I don't know how to
17 answer this problem, but the involvement of local
18 people, native people in the health care system as
19 professionals at all levels, I think the education
20 is available for people of the Northwest Territories
21 if they wish to take it, but I think that there is
22 a big barrier between that availability and the
23 actual achievement and I think that there could well
24 be some imaginative educational programs which would
25 ensure that a reasonable proportion of native people
26 in the Northwest Territories entered the health care
27 professions -- nursing, medicine, dentistry, as well
28 as social work administration, etc.

29 Q Are there any other
30 additions to the list before I move on?

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by Scott

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2 Well now, let me turn to
3 another question. I ask you to look insofar as you
4 can, at the project area which is the Mackenzie
5 Valley and the delta roughly, and have I drawn a
6 fair conclusion from what each of you have said that
7 at the present time the medical, in the broad sense,
8 the medical resource available in that project area
9 is operating and being utilized at capacity?
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Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by Scott

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2 THE COMMISSIONER: Dr. Cass
3 nods an assent.

4 MR. SCOTT: What do anybody
5 else who cares to express an opinion have to say?

6 WITNESS HILDES: I'm sorry.
7 I didn't quite get the gist of the question.

8 Q Well, if you take the
9 project area for the moment which is the Mackenzie
10 Valley and the Delta and look at the medical resource
11 in the broad sense that it's available to the people
12 now living in this area. Is it a fair observation
13 from your papers that it is presently being utilized
14 at capacity?

15 A Mr. Commissioner, I would
16 have to say I have no personal knowledge in recent
17 times of that area.

18 WITNESS SCHAEFER: If I may
19 address myself to this Commission. It is not utilized
20 to the limit of facilities right now in regard to
21 hospital beds available in Inuvik. There is a
22 reserve of fifty-five unused beds right now, but it
23 is operating at the limit of personnel and manpower.

24 Q All right. Could I ask
25 you this, Dr. Schaefer. Apart from the surplus bed
26 capacity at the Inuvik Hospital, leaving that as a
27 surplus, would it be correct to say that the medical
28 resource available in the Territory is otherwise being
29 used to capacity and I'm speaking of all three levels
30 of care delivery?

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by Scott

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A Yes, I think that's
a correct assumption.

Q All right. Now, let
me put this proposition to you. Let us assume the
construction of a pipeline in the project area will
commence in five or ten years and will run in each
case for a period of three to five years. Do you
have that in your mind.

We have been told that that
will bring into the project area five thousand persons
who will live in camps. I think the population of
the project area is between twenty and twenty-five
thousand people now. So, you will have an increase
in population of about twenty percent and perhaps
a little more. Arctic Gas has told us that in these
camps, they will provide some medical services, that
is they will be prepared to do cuts and bruises and
that sort of work but that anything beyond that, such
as broken legs and that sort of thing will be taken
to the community facilities, either in the communities
or in Yellowknife or Inuvik or perhaps in Edmonton,
where appropriate.

Now, confronted with a
population increase of twenty percent working people
exposed to the risks of on-the-job accidents, is it
clear that that kind of demand in five years is
going to substantially overtax the existing resource?

A The answer is a
definite yes.

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by Scott

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Q Now, let me add to this

the prospect which is not proved that in addition to those five thousand persons, there will immigrate into the Territory some two thousand other persons in search of employment and I take it it follows from that that that will simply exacerbate a serious problem that will then exist?

THE COMMISSIONER: Dr.

Cass nods in assent. I think Dr. Schaefer would agree with that.

MR. SCOTT: That will have increased the population of the project area by very close to thirty percent and I take it that, would it be fair to say that if resources remain what they are now, the stage will be a critical one?

A Yes, and I think we must also be realizing after the Alaskan experience that simply counting by numbers, saying twenty to thirty percent increase. That's what they did with other percentages and found then that the work load increased more than that because it is not just a simple increase by numbers but also other factors such as an increased V.D. rate even in the old populations there. Increased violence rate in the old populations there.

Q Now, my last question which has two answers and one of them is not permissible, I'll tell you in advance. Let me tell you what the question is. If this is going to happen,

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by Scott

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2 that is if the population of the project area is
3 going to increase by twenty-five to thirty percent
4 in five years and in this project it will not be a
5 gradual increase, it will be an increase that will
6 occur within a span of a year or so; if that
7 population increase is going to occur, what should
8 be done about it now?

9 Now, the impermissible
10 answer is that we must have a plan. I know that.
11 I want to know what the plan will be. What should
12 we be doing? What should we be buying? What should
13 we be providing? What should we be researching?
14 What should we be doing to meet this extraordinary
15 population growth?

16 A You gave already the
17 answer yourself; a contingency plan. It doesn't
18 matter what the decision of this Commission or the
19 government decision will be. A contingency plan should
20 then start now. If you want to have a hospital
21 operating in five years time, it's almost too late
22 for planning now.

23 Q Well, let me ask you
24 this then. Is it necessary in view of that population
25 increase that I've described, is it necessary to have
26 another hospital? Is it necessary to have more
27 nursing stations? Is it necessary to have more
28 personnel and in what dimension are these needs going
29 to occur?

30 A It may not be necessary

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by Scott

if it would be imposed upon the developers to fly their personnel out to other facilities and that only first aid attendance provided by their own personnel would be done there.

Q Dr. Hildes?

WITNESS HILDES: I take it that the construction site is not a single site. Therefore, one is not just building a new townsite with five or seven thousand people. Therefore, the idea of providing another nursing station or providing another hospital seems inappropriate to me but then I don't know. One cannot devise a plan without knowing what the plan of operation is.

As I understand it, there will be construction crews all along the pipeline route and this will involve several communities who are either on that route or close by it. Then those communities must have strengthened resources in terms of their required physical plant, if that needs strengthening or enlarging or more likely in terms of personnel who can handle a situation or more visiting personnel that would be appropriate to the broken legs you've mentioned and certainly a marked increase of it is not available in the ordinary way of transportation facilities for the transfer of people who require secondary and tertiary care into those levels.

Q Dr. Schaefer, do you have anything to add?

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WITNESS SCHAEFER: No, I

agree with Dr. Hildes because of the geographical drawn
out construction area. See the fifty-five beds
I spoke of in Inuvik cannot be used for that entire
length. It's not rational. It's not economical.

You might as well fly out
to Edmonton then. Therefore, the fifty-five reserve
beds will not alleviate the need of upgrading other
facilities along the line.

Q Well, if I was beginning
to draw that contingency plan this afternoon, what
other things would you tell me to look at? You're
the health care experts.

THE COMMISSIONER: Well, Dr.
Hildes, on page fourteen of your testimony, you made
eight recommendations. The last five of them would
appear to be the elements of such a contingency plan
though they are couched in general terms.

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MR. SCOTT: I take it, Dr.

Hildes, that those recommendations don't relate to a contingency plan but rather relate to the provision of services now, without any crisis.

WITNESS HILDES: No sir, not specifically. I think that the recommendations I made, the whole paper is based on the assumption that there is going to be an influx of construction people and industrial development, not to say that everything is perfect now. What I had in mind when I wrote this paper and made these recommendations, that there was some urgency because there would be a new influx of people and as Shaefer says, not only an influx of people but a new load of ill health on the people already existing, and on the facilities. So that I was going to comment before the Commissioner commented that that's what we've been talking about all day.

Q Well, I take it that none of you are in a position to project what those needs are. I'm not being critical, I'm just trying to find out if you are or if you aren't.

A You stopped us giving the answer. There ought to be somebody starting a planning process which we can't do in a half an hour now.

Q But we can project or I can give you certain assumptions about population growth in a period, I take it none of you are in a position now to interpret that in terms of new resources

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required, or expanded resources required.

THE COMMISSIONER: Or in terms of an increased number of nurses all along the valley or so many additional hospital beds in Yellowknife and so on and so forth. You don't feel that you're in a position to say anything?

WITNESS MAYHALL: If I could respond to that point. I think from a general standpoint we've all pointed out that population increase is one thing but that the other possibilities are the exacerbation of the health conditions of the people living there now. Now so you can't -- you have to do several types of planning, it's a very complex type of thing which involves trying to make predictions on what's going to happen to the present residents of the area who will be affected as well as the influx of new people and their demands. So that I think a multiplitorial thing which maybe some educated guesses could be looked at or could be considered but I think it would take some planning before it's possible to do it. I don't think it can be done on a short-time base. What we simply pointed out here in our presentation today, we can identify some of these problems; it's a matter of putting them together.

Q Let me see if I understand where this panel has gotten us. There are three areas, it seems to me, that you have discussed. First of all, if you have an increment in the population

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by Scott

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2 on the scale of 30%, then you will have to provide
3 health services for those people and that may be
4 by imposing certain terms and conditions upon the
5 pipeline companies for supplying their own health
6 services, or it may be by recommending to the Govern-
7 ment of Canada that they improve the, and enlarge
8 the existing health service to accommodate those
9 people. Now those people -- that is the newcomers --
10 when we speak of them and the health services they
11 require, in the discussion we've had it seems to me
12 we were concentrating on what I think you call trauma,
13 that is accidents and incidents of violence and so on.
14 But then the presence of those people and the develop-
15 ment itself may have an impact on the people who live
16 here now and will continue to live here when the pipe-
17 line is built, and when it is abandoned, I suppose.
18 That impact on the native population takes two
19 forms, as I understand your evidence. There is a
20 visible and immediate impact comparable to what has
21 been observed in Alaska, in the sense that you may
22 well have -- this is for the purposes of argument --
23 supposing that the pipeline project and related
24 development induced these changes. I'm not asking you
25 to tell me whether this will happen or not, You'll have
26 to leave that up to my judgment, but let us assume
27 that it does induce these changes. You will, among
28 the native people of this Territory, first of all have
29 the kind of problems, which I think Dr. Schaefer
30 emphasized in his submission, that you have in Alaska.

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by Scott

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2 That is an increase, you suggested, Dr. Schaefer,
3 of suicides, crimes of violence, increased alcoholism,
4 and child abuse and neglect, and the whole sorry
5 stream of incidents that flow from that kind of thing
6 and you have discussed that in your paper. That's
7 one kind of impact on the health of the people who
8 live here.

9
10 There's another kind of
11 impact that is over the long-term far more difficult
12 to predict or even to assess once it has occurred.
13 But Dr. Schaefer and Dr. Cass and Dr. Mayhall, you
14 all suggested that if the pipeline and related
15 development brought a further shift in the native
16 diet, that you could expect there to be an exacer-
17 bation of diseases that already exist among the native
18 people and their prevalence is in large measure owing
19 to their abandonment of their traditional diet by
20 the adoption of a local high-fat high-sugar diet, and
21 Dr. Cass referred to the prevalence of myopia and
22 attributed it to the change in dietary patterns.
23 Dr. Mayhall referred to the incidence of caries and
24 gum disease and attributed it to that shift in
25 diet; and there was, I think Dr. Schaefer put a gloss
26 on that, quite apart from shifts in diet, increasing
27 adoption of southern or urban customs by native
28 peoples such as abandonment of breast-feeding to
29 bottle-feeding, which isn't really a shift in diet,
30 it's obvious for the child, I suppose, but that
alteration in customs may among the native people

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by Scott

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2 bring about an incidence of disease, and you mentioned
3 middle ear disease.

4 Now, just before you all
5 -- I turn you over to Mr. Scott again -- does that in
6 a rough way set out the impact in terms of what will
7 occur to the health of the people in the north as
8 you've outlined them today?

9 WITNESS SCHAEFER: Yes.

10 Q Well, you all nod in
11 assent and I take it that I have done rough justice
12 to the case you've presented.

13 WITNESS MAYHALL: Yes sir.

14 WITNESS CASS: And the increase
15 of loss^{of} eyes --

16 Q Excuse me?

17 A Increase of loss of
18 eyes because what we get here has been terrible.
19 Since 1966 they seem to go for people's eyes, that
20 is they will get a person down on the ground and
21 they'll kick him in the face. I get fractured skulls
22 I had a boy who didn't drink himself, he went to the
23 toilet, was sitting on the toilet, a drunk came in,
24 smashed the door, kicked him in the face. He had a
25 fracture, both sides of his orbus. His one eye was
26 full of blood. He didn't lose his eyes, luckily, we
27 got him fairly quickly and we got treatment and then
28 sent him out to have his fracture dealt with. But
29 we're going to have more of this and I think we've
30 got to make provision for these people as well. It's

Hildes, Mayhall, Schaefer
Cass, Noble
Cross-Exam by Scott

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2 not only diet, it's going to be increase of violence.

3 Q All right. Now what
4 I'd like you to do, Mr. Bayly, maybe you would make
5 sure that the four medical people on the panel -- I
6 put Miss Noble to one side for this purpose -- get
7 a transcript of what has been said today from the
8 beginning of Mr. Scott's cross-examination on, and
9 including what I'm about to say now, which is
10 essentially this. If you accept that I've set out
11 fairly the range of impacts that might be induced
12 by the construction of a pipeline and related develop-
13 ment in this valley, and in the delta, what are the
14 chances, what do you say are the -- what is your
15 realistic assessment if you had to walk into the
16 office of the Prime Minister, say, and you outlined
17 these range of impacts and then he said to you,
18 "Well now, can we do anything about it? "

19 What is the realistic
20 assessment of the prospect of ameliorating these
21 things or/ preventing their occurrence?
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23
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Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by Scott

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2 I am not asking you to answer
3 that now but if you want to write a letter to the
4 Inquiry on that subject when you've thought about it,
5 we would like to hear from you.

6 Do you see what I'm getting
7 at? At the end of the day I have to go to the
8 Government of Canada and tell them what the impact
9 will be, what ameliorated measures I recommend and I
10 want you to tell me whether these measures you
11 recommended--Dr. Hildes has eight recommendations
12 on page fourteen. They're all good, I mean good stuff.
13 We could have a vote in this room and everybody would
14 vote for them.

15 But are those things--is there
16 any realistic process of achieving all of those
17 things? That's what I'm driving at. We don't want
18 to kid ourselves.

19 WITNESS HILDES: Are you
20 asking, Mr. Commissioner, that if given the ideal
21 conditions, whether the impact of pipeline construction
22 could be--the adverse impact could be completely
23 negated, or whether you're asking in another question
24 of whether the suggestions that have been made will
25 in fact ameliorate them?

26 Q No, I'm asking what
27 falls between. I think we would all agree, if we
28 did all the things you've recommended here, it would
29 ameliorate the impact, not completely but this isn't
30 a perfect world. No one would expect to ameliorate

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by Scott

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2 these things completely.

3 A You're asking how
4 realistic those things are?

5 Q Yes. Can we do these
6 things, assuming that were we to do them, they would
7 ameliorate impact. Maybe it's late and I'm losing
8 my train.

9 MR. SCOTT: Mr. Commissioner,
10 I've been listening to what you've said. Is the
11 question this, what things--first of all, what things
12 can be done to reduce or lessen impact from the kind
13 of population scenario that I outlined and secondly,
14 if those things are done, by men of good will, to what
15 extent will they reduce or lessen the impact?

16 A There's another question,
17 of course, that if a pipeline were not built, to what
18 extent will the events happen that we have outlined.

19 THE COMMISSIONER: Anyway,
20 you mean.

21 A Yes.

22 MR. SCOTT: Well, that's
23 the question I was going to come to next.

24 THE COMMISSIONER: Excuse me.

25 MR. SCOTT: I'm sorry, sir.

26 THE COMMISSIONER: No, that's
27 a good question.

28 MR. SCOTT: In trying to
29 summarize what I think you've said, you've all told
30 me that with the possible exception of the hospital at

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by Scott

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2 Inuvik, the medical resource available to the
3 Territories or the project area is being used pretty
4 close to capacity right now. I understand from at
5 least three of the papers, if not from all of them,
6 that even if there were no pipeline because
7 acculturation will continue at a more modest pace
8 perhaps, the situation is likely to get worse without
9 a pipeline coming on the scene. Now, do I have
10 that right?

11 A Well, it may not get
12 worse but it would get worse if there were no
13 attempts made to continue and advance, not to
14 ameliorate, but to prevent.

15 Q If we continue with the
16 resource we have now, and with the financial
17 commitment that we're able to make now, I take it
18 that with continuing acculturation even without a
19 pipeline, it will probably get worse.

20 A Yes, sir. That's
21 my opinion.

22 Q Is that the opinion
23 of everybody on the panel.

24
25 WITNESS MAYHALL: Yes.

26 WITNESS SCHAEFER: Yes.

27 WITNESS CASS: Yes.

28 WITNESS NOBLE: Yes.

29 THE COMMISSIONER: Excuse me.

30 You would be urging your program, Dr. Hildes, even if

Hildes, Mayhall, Schaefer,
Cass, Noble
Cross-Exam by Scott

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2 Arctic Gas and Foothills hadn't even thought of a
3 pipeline?

4 WITNESS HILDES: Yes.

5 WITNESS SCHAEFER: If I
6 understand the Commissioner and you, Mr. Scott, right,
7 you ask us in writing to make recommendations in case
8 a decision is taken to go ahead with the pipeline
9 development of measures to recommend, everyone of
10 us, measures which we think would ameliorate the
11 effect because we have down on record to say that
12 at the present stage, going ahead with a pipeline,
13 had more detrimental--that we expect more detrimental
14 than beneficial effects.

15 MR. SCOTT: Yes, I understand
16 that.

17 A So, you want now only
18 our recommendations in case a decision is taken?

19 Q I want you to plan for
20 the other case.

21 A All right. We'll go
22 home and try to do it because I do not think this
23 can be answered in ten minutes and certainly not in
24 a half an hour.

25 WITNESS HILDES: Do you
26 mind if we collaborate on the plane home, Mr. Commissioner?

27 Q No, we expect that and
28 I hasten to tell you that we have no way to compel
29 you to write us but your names will be forever marked
30 in my black book if you don't.

Hildes, Mayhall, Schaefer,
Cass, Noble

1 Those are all the questions I have, Mr. Commissioner,
2 and I want to thank the panel very much..

3 THE COMMISSIONER: You have
4 no re-examination?

5 MR. BAYLY: No sir, I don't.

6 THE COMMISSIONER: You want
7 to get off and get that plane so I'll excuse you but
8 just let me thank you all, Dr. Cass and Dr. Mayhall
9 and Dr. Hildes and Dr. Schaefer and Miss Noble. It's
10 been a long day but a most helpful one and I think
11 we've all learned, we have all learned a great deal
12 and I'm grateful to you all and I hope the medical
13 members of the panel will find time in their busy
14 schedules to reflect on these questions that Mr.
15 Scott and I have laboriously pushed around here the
16 last little while and get in touch with us.
17 So, thank you again.

(WITNESSES ASIDE)

18 (PROCEEDINGS ADJOURNED UNTIL SEPTEMBER 16, 1976)

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